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No. 15.

SOME POINTS IN THE OPERATIVE TECHNIQUE AND AFTER TREATMENT OF SENILE CATARACT EXTRACTION.¹

By W. Wallis Hoare, M.D. (Brux.), F.R.C.S. Edin., M.R.C.S., Eng.,
Brisbane.

To go into the history of the operation for extraction of senile cataract is unnecessary and undesirable. Suffice it to say that the original operation, devised and performed by Jean Jacques Daviel about the year 1750, consisting of a corneal incision downwards, opening of the lens capsule and expression of the cataractous lens, notwithstanding the lapse of time, has not greatly changed, although it has undergone many modifications.

Davel, all things considered, must have been a man of rare courage and resource, seeing that he did not possess a speculum, fixation forceps, or anaesthetic, and was innocent of any knowledge of asepsis. In this connexion it is recorded that his first patient lost his eye from suppuration, which indeed is hardly to be wondered at.

The operative treatment of senile cataract is of overgreen interest to the ophthalmologist. One favours the combined method of operation, another prefers simple extraction; yet a third demands extraction in the capsule; thus there is no standard or uniform method.

Now when one ponders, one finds many similar instances in general surgery; let me mention haemorrhoids as a good example, where the different methods of surgical treatment are numerous. Why is this so? Because, I take it, not one method gives uniform satisfaction in the hands of the many. One man swears by the Whitehead operation, another by clamp and cautery, another by excision and ligation, and so on.

I remember when engaged in general practice trying several methods, and not being quite satisfied with any, and at last, happening to read an account of Heygate Vernon's operation, I tried it, and never after departed from it. Of course one understands that while one method appeals to and suits one individual, it is, so to speak, anathema to another, who, possibly from one failure, is prejudiced against it; under the circumstances it would be incorrect to fasten the blame upon the particular method, which in other hands might have given an excellent result. Rather is it more correct to blame the operator, who neither suits nor is suited by that particular method. In the extraction of senile cataract the same applies, and hence the variety of methods. However, it is commonly agreed that all aim at the method promising the best result with the minimum of risk.

Before describing the particular method which, in suitable cases, has given me the most satisfactory results, I would like to advert upon the question, when to operate on senile cataract? In my

opinion that time is when the patient is no longer able to carry on, irrespective of maturation in the usually accepted sense of that term. The lens furthest advanced in opacity should be extracted. Should, however, the patient have only one eye potentially good in a visual sense, the other from any cause being negligible, and can afford to wait without detriment to health or pocket, it is a matter of choice. The practice of telling a patient of 70 and upwards to wait until he is quite blind in one eye is, I think, unsound and unsurgical. An average patient of that age cannot hope to live very long, and if such a patient is to be saved from a miserable period of waiting, involving melancholy, apprehension, hesitancy, with probably distinct decline in such bodily health as he or she may possess (the almost invariable concomitants of slowly supervening blindness), then surely it is the obvious duty of the surgeon, provided it can be done, to operate forthwith on the lens furthest advanced, provided the patient cannot longer carry on. I have had quite as good results from immature cataract operations as from mature, and provided there is no evident complication in the eye itself or any departure from general health present, the fact of a senile cataract not being fully matured never deters me in the slightest from operating. I think this view is now becoming more general, notwithstanding the former prejudice against operating on unripe cataract. My personal experience has convinced me that care in incising the anterior capsule, preferably by a ring-shaped incision, getting the cystitome well under the edge of the iris sphincter all round and thorough irrigation of the anterior chamber as the last step in the operation, renders the probable onset of iritis from retained lens matter or the formation of after capsulo-lenticular cataract unlikely and capable of being neglected.

Unless warned by a culture from the conjunctiva that there is danger, I content myself with the instillation of a 25% argyrol solution three times a day for a couple of days prior to the operation, and thorough irrigation with normal saline solution of the conjunctival sac immediately before commencing the operation. I am a firm believer in argyrol, but possibly other drugs would do equally well.

Quite the most important ordinary danger attending the operation for extraction of senile cataract is that the patient will squeeze and lose vitreous; consequently it is my practice now almost invariably to have the lids held apart with retractors by an assistant. The retractors are Lang's or Harman's, and the important point to remember in this matter is, as Smith in his small work on cataract points out, that the assistant should pull the upper lid forward away from the globe, not upwards toward the eyebrow. Smith uses a squint hook, or rather his assistant does, but I find the Lang retractor easier for the assistant, who rests the little finger on the brow and with the thumb inserted in the free hook, pulls the

¹ Read at a meeting of the Queensland Branch of the British Medical Association on March 1, 1918.

lid well away from the globe, so that by no ingenuity can the patient squeeze the globe with the orbicularis muscle. The lower lid is pulled down with another retractor. Undoubtedly it is easier to make a precise incision if the ordinary speculum is used. When this is completed the retractors are then employed, but, and "but is reflection," as Thackeray in his immortal novel "*Pendennis*" points out, one cannot guarantee that a senile, nervous or unreliable patient will not squeeze on the slightest provocation, and although the difficulties of the operation are increased by the presence of the assistant's hands, the added security in the operator's mind materially outbalances the objection. The loss of vitreous—I care not who denies it—is, in an intraocular operation, a calamity comparable to shock, haemorrhage or sepsis in general surgery. Be it understood, one does not contend that the use of retractors absolutely prevents the loss of vitreous. A defective zonula and liquid vitreous may cause this untoward happening despite every precaution, but even so the loss will be less and the likelihood of loss less, than when the ordinary speculum is used. Another drawback attending the use of retractors is the greater difficulty in getting the lens to present and make its exit owing to the collapsible condition of the globe induced by pulling away the lids, very noticeable in some cases, but after all it is not a very serious drawback.

Every ophthalmic surgeon is agreed upon the necessity of an adequate incision, puncture and counter puncture which should embrace at least one-third of the corneal limbus. With regard to the conjunctival flap, there is diversity of opinion. I confess to being biased in its favour and always make one when completing my incision. At one time I made my capsulotomy with the point of the Graefe knife, dipping it as it crossed the anterior chamber, but I have practically given this up as I find it more satisfactory to use a cystitome and make a ring-shaped incision, getting the cystitome on the flat well under the edge of the *sphincter iridis* and, having made a half turn, incising the anterior capsule all round. In this way the absence of anterior, capsular remnants in the pupillary area is ensured. This is not difficult to do, save at the upper part of the pupil in some cases. In most the aqueous escaping causes the pupil to assume an oval shape upwards, thus simplifying matters.

The expression of the lens should be an essentially slow and gradual process, deliberate yet intensely gentle, the idea being slowly and gradually to stretch and tire out the iris sphincter and to avoid rude dilatation or rupture.

The next step is perhaps the most difficult of the whole procedure, *viz.*, making a peripheral iridectomy. My early cataract extractions were nearly all simple extractions, as I had imbibed the elements of ophthalmic surgery from Mr. Stanford Morton, who, at that time, largely affected it, and who performed it with the skill of a master, dipping the point of his knife and snicking the anterior capsule as he carried it across the anterior chamber. Having had some updrawn and oval pupils as a final result, I came to

the conclusion reluctantly that the method was overrated, and I now, where circumstances permit, always make a peripheral iridectomy. This is made obviously after the expression of the lens. Sometimes when the iris has become flabby and prolapsed into the wound, it will be necessary, first, to repose it with a spatula, then to make the patient look up or even to irrigate gently to encourage return of tone to the sphincter. In making the iridectomy, it is of course essential to have good light and to get the patient to look well down. When the closed tips of the forceps have been introduced into the wound, the handle is brought well forward, at the same time the points are dipped and opened very slightly and a very small portion of iris tissue close to the periphery or root of the iris is seized. The object is to make a tiny opening with a good band of iris between it and the pupillary edge. The standard size of the coloboma aimed at should be about the size of a pin's head, but, given a fair band of iris tissue between the opening and the edge of the pupil, the size does not really matter. Finally, the anterior chamber is well flushed out with lukewarm or warm normal saline solution and a couple of drops of a sterilized 0.5% eserine solution are dropped into the conjunctival sac. The usual toilette of the wound is made, the retractors are taken from the assistant's hands and carefully removed, and the upper lid is gently drawn down by the operator. A very soft sterilized swab, well smeared with sterile vaseline, is placed over each eye and held lightly in place by adhesive plaster, and over all a wire mask is applied so that the patient in a moment of forgetfulness can not touch the eye or no pressure can be exerted upon it by the nurse's hands, pillow or bed-clothes.

The use of eserine is said by some to be useless, by others to favour the formation of posterior synechiae. Having used it consistently for 16 years, I am satisfied that it is of the greatest use. With regard to the second charge, I merely point out that atropine can be employed the following day if desired. I have found that the slow method of delivering the lens, involving as it does continued pressure on the cornea and irrigation of the anterior chamber with saline solution, certainly tend to cause *keratitis striata*, but if so what of it? It is practically always gone within a week.

It is held by some that extraction without the usual preliminary iridectomy should never be done in the aged. This, in my opinion, is a statement largely based on theory, not on practice. I have extracted the lens often in patients over 70 and over 80, leaving round or almost round pupils. I see no reason to discontinue doing so. Should a case with an iris which is atrophic present itself, it would, of course, be the height of folly to attempt to express a large and hard nucleus through it with the view of preserving a round pupil. It is also said, and Morton used to be emphatic on this point, that in small or contracted pupils simple extraction should not be attempted. Yet I found that a fairly large lens can be quite successfully coaxed through such pupils, if only the fact be borne in mind that the *sphincter iridis* can be tired out, just like the *sphincter ani*.

The assistant who holds the retractors, should not be possessed of nerves, nor should the attention wander for one moment from the business in hand; the eyes should be fixed on the retractors, otherwise catastrophe may take place. No force is required, simply steady traction.

The advantages of a peripheral iridectomy over simple extraction are the danger of iris prolapse into the wound is considerably lessened, owing to the little drain hole or sluice gate permitting the aqueous to escape should the patient squeeze or strain during the first few hours; thus the round pupil is preserved. Over the ordinary iridectomy the fact that the pupil can contract quickly and shut out excessive light is a very important point in our tropical and sub-tropical climate of Queensland, where the usual coloboma, often I think quite unnecessarily large, causes a considerable amount of dazzling. Last and least is the cosmetic advantage, because it is difficult to see the peripheral iridectomy unless one searches for it.

The cases you have seen to-night are examples of the operation which I have described. The first patient, aged 66, a year after the operation had $\frac{1}{2}$ vision, and J1. He had a mature cataract and had to be needled once. The other patient, aged 60, had a hypermature cataract. He had been blind for seven years in that eye, with marked iridodonesis. He did not require needling, and has now $\frac{1}{2}$ vision and J1. I particularly wished to show you a gentleman, aged 78, who had an unripe cataract with a similar result without needling. Unfortunately he has not responded to my invitation; possibly he did not receive my letter.

A case I wished very much to show here to-night is that of a man, aged 84 who, during the extraction of a left mature cataract and subsequently, underwent somewhat alarming vicissitudes, but he is confined to his bed with an attack of rheumatism. At his operation all went smoothly up to a certain stage, the lens was expressed through a round pupil, when the assistant in charge, for a moment allowed the retractor under the upper lid to relax, the patient squeezed *con amori*, and vitreous squirted out. A liberal dose of eserine was dropped into the conjunctival sac, the eye dressed up, and the patient returned to bed. Next day the pupil was well contracted, but, strange to relate, there was a fair-sized air bubble in the anterior chamber, which, with every movement of the eye, peregrinated about the chamber just as the bubble in a spirit level moves when the level is altered. For five days the bubble remained in the eye, which was perfectly quiet and free from pain, though the patient asserted that he felt as if something were in his eye. He was what might be called a "chronic squeezer," and I was almost afraid to look at his eye lest he would squeeze out more vitreous. On the fifth day, however, I decided, perhaps somewhat tardily, that as I was unaware of the particular bacterial contents of the air bubble, and as it showed no sign of absorbing, I would do a paracentesis and release it. He was taken to the operating theatre, but when the first drop of cocaine reached his eye he gave a mighty

squeeze, burst open the wound at one place, ejecting aqueous and the air bubble most satisfactorily. It is unnecessary to relate that he was sent back to bed without any undue delay. He has now a fairly good eye, excellent from a cosmetic point of view, with vision sufficient for his purposes, though not up to standard.

I believe in getting aged patients out of bed a couple of days after the operation when possible, and practically all my patients with senile cataract are out of bed four or five days after. I see no advantage once the wound is sealed in keeping a dressing on the eye. I think it is sounder practice to protect the eye from light during the daytime by means of dark glasses, and from injury at night by means of a wire mask. In Australia, where many aged patients develop conjunctivitis in an eye bandaged for even twenty-four hours, it is surely unwise to keep an eye bandaged for several days after a cataract extraction.

The question of after-cataract hardly enters into the subject I have touched upon, but I may say that I quite agree with Colonel Smith, who writes: "Many advocates of Daviel's operation have a tendency to make light of after-cataract and its treatment . . . an intelligent patient does not make light of either." It is certainly unpleasant to have to tell a patient after a cataract operation that a second and even a third operation will be necessary to achieve the required visual result, yet the sad fact remains that a very large number, irrespective of the type of operation, have subsequently to undergo dissection.

THE PREVENTION OF POST-ANÆSTHETIC VOMITING.

By S. J. Cantor, M.B., B.S., Acting Anæsthetist,
Perth Public Hospital.

The following simple treatment has been found to be almost always successful in preventing the vomiting that frequently follows the administration of a general anaesthetic. It was first tried on several hundred patients whom I anaesthetized at the First Australian General Hospital during 1915, and since in a number of cases both in military and civil work. I have never seen any reference to the method in any publication, and believe it to be new. I first employed it in military cases as the necessity arose to prevent vomiting during the course of operations in which a minimum of anaesthetic (generally ether) was given, or during the analgesic stage following the termination of the administration of the anaesthetic. Whether signs of impending vomiting, e.g., swallowing movements, are just appearing, or if vomiting has already occurred, the treatment is the same. The nostrils are firmly squeezed with the fingers, so as to occlude the airway through the nose. The vomiting movements then cease immediately. There also result a deeper narcosis, as evidenced by a less active reflex, and often slight cyanosis. If the latter is marked, the lower jaw

must be pushed down to give an airway by the mouth. In a very small percentage of cases it is necessary to free the nostrils momentarily till a breath is taken, to prevent severe cyanosis or deep narcosis.

As a result of the pressure on the nostrils, as just stated, the vomiting movements cease. The pressure can then be released. In some cases, especially when ether has been given, a small quantity of salivary secretion and mucus is regurgitated from the region of the pharynx, but actual vomiting rarely occurs. At times the procedure has to be repeated later if vomiting again tends to occur.

The method probably acts by rapidly superadding a carbon dioxide narcosis to the anaesthetic narcosis, but the action is so rapid that there may be a direct reflex action of an inhibitory character concerned. Neither stimulation nor pressure applied about any portion of the face prevents the vomiting. The former hypothesis, therefore, is the more likely. No ill effects have occurred as a result of using this method, and in almost all cases vomiting, especially that occurring before the patient has left the operating table, can be prevented.

Reports of Cases.

SOME NOTES ON ABDOMINAL CASES.¹

By T. H. Morgan, M.D., M.S., F.R.C.S. (Edin.),
Brisbane.

Injury to Bladder.

Miss P.T., aged 21 years, was admitted to Hospital on January 12, 1916, at 10 p.m.

History.—Whilst going out to post a letter that evening she fell from the steps of her house on to a rose bush in the front garden. Proping up and in the centre of this bush was a broom handle, which entered the vagina and passed right through the bladder into the peritoneal cavity. Her cries for help brought the parents to her aid, who gently lifted her out of the position.

Immediately she called out, "My inside is coming down." She was conveyed to the General Hospital by ambulance. I was called to see her about 11 p.m., when I found her pale and collapsed with several inches of omentum protruding from the vagina.

After thoroughly cleaning up the parts and examining, some 25 centimetres of omentum were removed from the vagina. Then it was seen that the bladder and not the uterus had been punctured by the foreign body.

The abdomen was now opened and the wound in the fundus of the bladder found and closed by two tiers of catgut sutures. On further examination only intestinal abrasions could be seen apart from the bladder wound. The abdominal wound was drained, the wound in the bladder was sewn up, the vagina packed with iodoform gauze, and a catheter left in the bladder. The patient was returned to bed and placed in the Fowler position.

Everything went on well for four days: there was the usual vomiting; the kidneys soon resumed their normal function, and the bowels acted the third day. On the fourth day the discharge from the abdominal wound was becoming offensive.

On the fifth day it was evident that a faecal fistula had formed. The catheter was left out on the ninth day. The faecal fistula continued to discharge until February 9, when it ceased. The patient left the Hospital, six weeks after admission, on February 23 in good health.

I have seen this lady several times since. She is one of the smartest girls in Queen Street. She has absolutely no inconvenience with the bladder. I feared at first that she would suffer from bladder irritability, but she has none.

Intraperitoneal rupture of the bladder in the female is relatively rare, especially when it is caused by the penetration of a broom handle. I have known a somewhat analogous case in the male. A man fell from a counter on to a broom handle, which penetrated the anal orifice and thence passed through to the peritoneal cavity. This poor man died some five or six days later from general peritonitis.

Hernia on Glissade.

Two years ago a man was admitted to the General Hospital with a double hernia, that on the right side being larger than that on the left. I decided to operate on the right side first.

On opening the sac I was confronted with a condition I had never seen before. It seemed that the caecum and the appendix had bodily slipped down into the inguinal canal, carrying with it the peritoneum as it passes from the intestines to the parieties.

I was unable to empty the sac of the intestines, owing to the broad attachment of the caecum to the posterior wall of the sac, which band carried some larger vessels, *viz.*, the vascular supply of the intestines. All I could do was to free the sac as far as I could diminish its size by suture, fix the internal oblique to Poupart's ligament, close the wound and insist in the patient wearing a truss.

On the opposite side was a hernia of the usual type; this was fixed up a fortnight later.

Torsion of Omentum.

Some two years ago I was called to the General Hospital one night, to what was believed to be an acute case of appendicitis. A man, aged 45 years, had been admitted with pain in the right side of the abdomen and some fullness and rigidity in the right lower quadrant of the abdomen. The pain was acute; he had vomited; his bowels had been open the day before. There was no history of any previous attack. There was a history of right inguinal hernia, but as that was not down, no particular notice was taken of the history.

Believing the condition to be an appendicitis, I opened the abdomen with a view to removing the appendix, when a large portion of the right half of the omentum was found to be deeply congested and of a dark plum colour, owing to torsion and thrombosis of its vessels. On drawing this out of the wound, I felt a part of the mass suddenly escape from some imprisoned spot; this was probably an old hernia sac which had not been in evidence before the operation. After a considerable mass of omentum had been extracted, it became possible to ligate it off easily. One might almost say that a definite pedicle presented itself. The appendix was normal, and no trace could be found of the agent causing the torsion of the omentum. Probably it had been the sac of the old hernia in the inguinal canal.

The following opinion has been expressed by Adams and Cassidy:

Torsion of the omentum may occur in a hernial sac or within the abdominal cavity. Primary abdominal torsion is distinctly rare; Corner and Pinches (*Trans. Med. and Chirurg. Soc.*, Vol. 88, 1905) give details of only six cases.

Inside the sac of a hernia, torsion is not uncommon, and the symptoms it produces are those of some degree of strangulation associated with the presence of an irreducible hernia; in some cases the origin of the twist may be attributed to the existence of a hernial sac, but the omentum may be withdrawn into the abdominal cavity and yet the symptoms persist. Concerning torsion apart from a hernial sac, no satisfactory explanation can be given; but it is to be observed that in all the six cases collected by Corner and Pinches the tumour was in the right half of the abdomen. The symptoms are very variable, and pain is the only one which is constantly present. Vomiting and constipation may be observed, but there may be diarrhoea. In some cases the clinical picture has been that of obstruction, with considerable abdominal distension due to reflex paralysis of the intestine. The temperature and pulse-rate are usually above normal. There are no physical signs which are at all characteristic of this lesion, but in cases where the his-

¹ Read at a Meeting of the Queensland Branch of the British Medical Association on February 1, 1918.

tory points to hernial trouble, and an empty sac is associated with an abdominal tumour on the same side as the hernia, a suspicion of twisted hernia may be aroused. In cases of pure abdominal torsion there is definite local resistance, or even a palpable mass, in the abdomen, but as we have already stated this is situated, in nearly all cases, on the right side, and therefore the appendix comes under suspicion. In the female such a lesion would probably be mistaken for a small ovarian cyst with twisted pedicle.

Gastro-Duodenal Ulceration.

I have had four cases of gastro-duodenal ulceration lately, for which gastro-enterostomy was done.

One was a chronic gastric ulcer. Three were chronic duodenal ulcers. Taking the gastric ulcer first,—

Miss W., aged 26 years, a stewardess, consulted me on June 11, 1917. She has had pain and vomiting at irregular intervals for some years. There were intervals of severe vomiting. After a rest and treatment she was comparatively well again. About a year ago she consulted a very good man in Sydney who advised an operation. He opened the abdomen, but as he could find no trace of ulcer of stomach or duodenum that would account for the symptoms, he closed up the wound. He then explored the appendix region and removed the appendix. Patient states that she was no better after the operation, but vomited daily for the last twelve months, and just a week before consulting me she vomited about a half of a litre of blood. This was the first blood she saw, but as most of her later years have been spent afloat, and as she usually managed to get to the lavatories and vomit therein, it is very likely she had vomited blood before without noticing it.

On examination, she had, on pressure, a painful spot in the pyloric region, and also on taking food she had much pain and fullness in that region. She also complained of giddiness. She had not taken meat for months, and had lived upon milk. She was admitted to private hospital, put to bed, carefully dieted, and was given gastro-lavage daily. This relieved the vomiting, but did not relieve the soreness or pain and fullness on taking food. After ten days of this treatment, as she was no better, her condition was discussed, in consultation with Dr. Meek. The facts were laid before her friends, and it was decided to operate.

The operation was difficult, owing to very dense adhesions, which were most noticeable around the pylorus and lesser curvature, where an ulcer was located.

Posterior gastro-enterostomy was performed.

She made an uninterrupted recovery after the operation, and left the hospital some four weeks later. I saw her again in September, some five weeks after leaving the hospital. She had put on 6.35 kilograms (a stone) in weight, and had only vomited once or twice since leaving the hospital. She joined her ship in the latter part of September, and is now practically well.

She suffered from sea-sickness on the first voyage after the operation.

Rev. K., aged 50 years, consulted me in July, 1915. He had been ill for years with indigestion. For the last year he had a hungry feeling coming on one to two hours after meals; a kind of false appetite. Gradually the hungry feeling became painful. Under treatment he would improve for a few weeks; then the attack would return and last from three to six weeks, and he would again improve somewhat with rest, diet, and suitable medication.

He vomited frequently for quite a month before coming to the hospital, and one week before he noticed he was passing blood from the bowel. He never vomited blood.

On examination it was evident he was losing flesh. There was much pain on pressure in the region of the pylorus. There was no tenderness in the gall bladder region. The abdomen was opened and a large ulcer of the duodenum was found, quite 4 cm. from the pylorus.

Posterior gastro-enterostomy was done. The patient rallied well from the operation. Unfortunately, on the third day he began to pass blood *per anum*. This continued for three or four days, giving us very much concern. Probably he lost a litre of blood *per anum* in the four days. We tried many things by the mouth, including bismuth, opiates and serum. Lastly, on the third night, the subcutaneous administration of 850 c.c.m. of saline solution rallied him, and thereafter

the bleeding became much less, and gradually ceased. He got on well, lost all his gastro-duodenal symptoms, has kept well ever since, and is now, two years after, in better health than he has been for some years.

Looking back upon this case, you may say that it would have been better to have operated in the interval between the attacks when there was no bleeding. My answer is, the urgency of the case demanded that something should be done, and done speedily, because he was vomiting freely and losing much blood *per anum*, and he certainly was looking white and showing some signs of exhaustion.

Further one might have excised the ulcer or top-sewn it. Personally, I have not excised an ulcer, and at the operation my colleague's advice was in favour of the gastro-enterostomy and giving rest to the part.

G.W.S., aged 43, a butcher, consulted me in October, 1916, for pain in the region of stomach when taking food, also about two hours after eating the pain came on in the region of the sternum as well. This gradually became worse, until he vomited. He had had vague stomach symptoms for twelve months, and was gradually losing flesh. For some weeks he had parted with one of his meals, usually his breakfast, each day; the other two light meals were kept down.

As this man was cachetic, and had much pain and vomiting, I diagnosed probably malignant growth. He was admitted to the hospital, and the abdomen was opened. A growth was found in the first part of the duodenum, quite the size of a duck's egg. This we took to be a malignant tumour. Posterior gastro-enterostomy was done, with a view of getting up his strength and to permit a pyloromy or partial gastrectomy in about six weeks after the primary operation.

Patient got on well, and the vomiting quite all stopped. He began to put on flesh, and was quite agreeable to the second operation, if it was necessary. In six weeks I re-opened the abdomen, only to find that the supposed tumour had quite disappeared. Evidently it was of inflammatory nature. Looking back upon the case, I am not sure that a bismuth meal would have helped to show the disappearance of the supposed tumour. Had we not operated and the tumour gone on growing, at the most, 12 months would have seen the end of our patient. So, conscientiously, I believe the best was done for the man. He got quite well, and is performing clerical and office duties in a large butchering establishment since December, 1916, is quite well and strong and eats practically anything.

Mr. A.B., aged 29 years, consulted me six months ago for stomach trouble. Periodically he got attacks of discomfort and fullness in the stomach, which culminated in a vomit. These attacks lasted for three days or thereabouts, during which time he vomited several times. Quite a week elapsed before he could resume his usual diet. During his attacks it was noticeable that he lost weight freely, and considerably more than he gained in the interim between the attacks. He never vomited blood; the vomit consisted, first of all, of food, and, later on, of bile. The bowels were constipated. There were no renal complications, no pulmonary, and no cardiac trouble.

History.—Some eleven years ago he was in an explosion of petrol on board a motor boat. He was badly burned about the face and arms, but not about the body. He had never enjoyed robust health since. Stomach symptoms followed this accident. He went to England, and Dr. Soltan Fenwick treated him for stomach ulcers for six or eight months, but he never got well.

Not content with our diagnosis, he went to Sydney and saw Sir H. Maitland, who urged that the operation should be done as soon as convenient. He returned to Brisbane. I operated in September, and found extensive adhesions around the duodenum, and a considerable dilatation of stomach, with pyloric stenosis. The stomach was one of the most vascular I ever saw, as evidenced by the large number of big veins in its walls.

Posterior gastro-enterostomy was done. Everything went well till the eighth day. On that day he had an egg for breakfast, and was to have some minced chicken for dinner. But about eleven o'clock he suddenly said he was sick, and straight away brought up some pints of fluid looking much like custard. Again that afternoon he vomited one to one and a half litres of the same fluid.

Now, in operating, I was most careful to leave no loop of jejunum for a vicious circle to form, but, remembering

that the stomach was much dilated, it seemed very probable that the gastric dilatation had sagged toward the duodeno-jejunal junction, allowing that portion of the loop to become water-logged with fluids, which then regurgitated through the anastomotic opening.

However, gastric lavage for three mornings cleared up all the untoward symptoms. He progressed well, left the hospital in a month, and is now at the coast, convalescent.

Reviewing these four cases, one of gastric ulcer and three of duodenal ulcer, I am only reporting the immediate results.

I have sought to answer the question: Have I done all that could have been done for these patients?

Some twelve years ago in England I had the advantage of seeing gastro-enterostomy done eight or ten times by Mr. Mayo Robson and by the late Mr. Barker, also by Mr. Mc-Adam Eccles. For chronic gastric and duodenal ulcers, in none were there any resections of the ulcer done.

Mr. James Sherren, writing on the prognosis and end-results of operations on the stomach, says:—

With regard to the remote results of surgical treatment, it is undoubtedly that the majority of patients with chronic gastric ulcer wherever situated are cured as the result of gastro-jejunostomy alone.

The late Professor Kocher, to whose opinion great weight must be attached, was satisfied that in his hands gastro-enterostomy will cure a gastric ulcer, wherever that ulcer may be.

H. Patterson ("Surgery of the Stomach," pp. 86-94) also considers that, even if the ulcer lie near the cardia, or at any part of the body of the stomach, the anastomosis of the stomach with the jejunum will allow or even encourage the ulcer to heal. These writers believe in the "physiological effect" of a gastro-enterostomy as something different from its merely mechanical effect. Patterson asserts that the entry of the intestinal contents, bile and pancreatic juice into the stomach, neutralizing the acidity of the gastric juice, has a very decided effect in allowing an ulcer to heal.

Moynihan, after much discussion, says:—

This then became our plan of procedure. If an ulcer lay in the pyloric region, either in the duodenum (far more frequently) or in the stomach (rarely), and was causing stenosis and was clearly not malignant, gastro-enterostomy was performed. If a single ulcer lay in the body of the stomach and was not causing an hour-glass deformity, it was excised.

If an ulcer near the pylorus was very thick, much indurated, and possibly malignant, or if ulcers were multiple, Rodman's operation was considered to be necessary. Dr. Wyllys Andrews, in the *Medical Annual* for 1917, says:—

In the past year it has been more and more evident that gastro-enterostomy alone does not give the best results. It will not cure more than 50% of gastric and 75% of duodenal ulcers, according to statistics from numerous clinics. There is, therefore, need of further surgery, and we are faced with the fact that gastro-jejunostomy has a mortality of 1½% to 2%, while any further work increases this tremendously, and the most radical procedure—partial gastrectomy—has 25% to 30% mortality. The fact, however, that about one-third of those not cured by gastro-enterostomy develop cancer within five years, coupled with the inadequacy of simple anastomosis, justifies a greater risk.

Liek thinks that the decisive factor in the choice between resection and gastro-enterostomy is the danger of the operation. He says the mortality of resection is considerably higher than that of gastro-enterostomy. Kuettner, in 1914, found for resection a 20% mortality and for gastro-enterostomy only 4%. Statistics gathered from the literature of 465 cases show a mortality of 10% for resection, and for gastro-enterostomy from 3% to 6%.

Reviewing the opinions of these authors, my answer to the question: Have I done all that could be done for these patients? is, I believe that for the three duodenal cases and the pyloric ulcer case, the operation of gastro-enterostomy was, in all probability, all that was justifiable. Should further symptoms arise, such as vomiting, pain, or haemorrhage, one can then proceed to the second stage of the operation, *viz.*, a pylorectomy or partial gastrectomy.

Referring to complications, in my second case there was considerable bleeding noticed on the third, fourth and fifth

days after the operation. About a litre was probably passed *per anum*. It is possible that I may have pricked a vein in the wall of the stomach and not noticed it, or the duodenal ulcer may have continued to bleed after the operation. It is a well known fact that a chronic duodenal ulcer may continue to bleed after a gastro-enterostomy.

I may say I used a continuous suture throughout, drawing it firmly and evenly after each stitch. My belief is that the haemorrhage was from the ulcer, which continued bleeding, especially after the necessary manipulations, gentle though they were, in doing the operation.

In the last case we had an experience of regurgitant vomiting, which at first threatened to be an ugly symptom.

There are four varieties of misdirected current after gastro-enterostomy:—

- (1) Regurgitation of duodenal contents through the pylorus.
- (2) Escape of fluids from the stomach into the afferent loop.
- (3) Escape of fluids from the afferent loop into the stomach.
- (4) Regurgitation of the contents of the efferent loop into the stomach.

In this case there was much gastric dilatation prior to the operation, and whilst I was as careful as possible to leave no loop between the duodeno-jejunal flexure and the anastomotic opening, I believe, that by gradually increasing his food, we had increased too rapidly for the slowly improving gastric tone, with the result that the dilated stomach sagged towards the gastro-jejunal flexure, temporarily displacing the new stoma, and thus producing the regurgitant vomiting.

Gastric lavage for three successive days fortunately dissipated all the untoward symptoms. Thereafter the patient progressed very satisfactorily.

A CASE OF INJURY TO THE EYE BY THE BURSTING OF A LIQUID CORE GOLF BALL.

By J. C. Halliday, M.B.,
Honorary Assistant Ophthalmic Surgeon, Royal Prince Alfred Hospital, Sydney.

The patient, A.H., a boy of 10 years, was admitted to the Royal Prince Alfred Hospital on December 4, 1917, with the story that, while sawing through a golf ball the day before, some white fluid from its interior flew up and struck him in the right eye. On examination there was great swelling of the eyelids and chemosis of the conjunctiva, together with photophobia and a serous discharge. At first the cornea was clear, but a fortnight later became somewhat steamy. The swelling of the conjunctiva slowly subsided, leaving it mottled in red, brown and green patches. In about five weeks the eye was settling down to normal.

In the *British Medical Journal* of March 20, 1915, R. H. Elliott and W. S. Inman report a similar case followed by almost complete loss of sight. The literature of the accident, which appears to be common in America, is referred to, and analyses of the fluid contents of various golf balls is given. Some were found to contain barium sulphate, soap, and free alkali, others sulphuric acid, and others again chloride of zinc and soap. The danger attending the opening of these golf balls should be realized by the public and by golf players particularly.

A BULLET WOUND OF THE ABDOMEN.

By Archie Aspinall, M.B., Ch.M.,
Honorary Assistant Surgeon, Sydney Hospital; Honorary Assistant Surgeon, Royal South Sydney Hospital.

The following case is recorded on account of the unusual conditions of the wounding of the abdomen by a bullet.

The patient was a boy, 17 years of age, a saw sharpener, who had been camping at Woy Woy. While cleaning a pebble, the weapon had gone off and the bullet entered the abdomen 2.5 centimetres above and to the left of the umbilicus, taking a downward course. He was admitted to the Sydney Hospital on December 25, 1917.

On examination it was found that the wound of entry was blackened round the periphery by powder, 2.5 cm. above and

to the left of the umbilicus. The temperature was 37.° C. and the pulse-rate 98. There was no rigidity and no vomiting. On the 28th, Dr. Edwards reported that the X-ray examination revealed a foreign body in the right lumbar region anteriorly, probably in the liver. It moved with respiration.

The patient had been kept in the meanwhile at rest and was given only sips of water by the mouth. On the following day an enema was administered and a pea rifle bullet and cartridge case were found in the resulting evacuation. The case was bent up over the nose of the bullet. The patient's explanation of this curiosity was as follows. A cartridge had become impacted in the breech. To remove it, he had placed a cartridge in the muzzle and had fired it by hitting it with the handle of a knife. This manoeuvre had been successful, but the cartridge case had been left in the muzzle. He had then loaded the rifle again and it had gone off accidentally, wounding him in the abdomen. The bullet, as it left the barrel, had become impacted in the cartridge case at the muzzle, and the two entered the abdomen together. On January 9, 1918, no foreign body could be detected by X-rays. He was discharged on January 18, 1918.

It will be noted that the line of treatment adopted was conservative. The abdomen was not opened, as the patient did not have any urgent signs. The skin wound had been freely opened and cleaned on admission, and the patient was starved for several days.

Reviews.

DIABETES AND FASTING.

Treatment of diabetes by fasting and dietetic methods, based on F. W. Allen's experiments, is so much in the mind of the medical profession to-day that an authoritative manual, dealing with a large number of cases, based on these methods, is very welcome, and the new edition of Joslin's book may be cordially recommended to all who have to treat this very serious condition. A careful perusal of Joslin's book¹ will instill hope into the minds of the practitioner; and the patient, if he will read the "Things which every diabetic ought to know," given on page 470, *et seq.*, will be likely to help in his treatment and to follow out the necessary restrictions placed on his diet. In his preface, the author states that "It is now possible to be more definite in describing treatment, and this is particularly true of what is written about acid poisoning. To-day I can furnish facts in support of my practice of not giving alkalies in the presence of threatening coma. The advances in the treatment of diabetes, which began with the introduction of fasting by Dr. F. W. Allen, continues, and statistics are now available to show it. So-called acutely fatal diabetes is disappearing, and the first year of diabetes is no longer, as was only too recently the case, the diabetic's danger zone. Already I have quite a series of patients who have outlived their normal expectation of life at the age of onset of their diabetes." This is a statement full of hope, and the statistics given in the book itself justify the hopefulness.

The work is a thoroughly full discussion of all the problems of diabetes, and is essentially understandable. The more recent methods of chemical examination of blood and urine are carefully set out, and estimations given of their value in the management of the case.

In the section dealing with treatment will be found full details of methods of managing all the different kinds of cases. Emphasis is laid on the necessity of educating the patient and his attendants, and much valuable advice is given. The importance of limitation of protein and fat in the diet is insisted on, and the need of pancreatic rest at frequent intervals is pointed out.

Full lists of the constituent values of foods are given, with their caloric values, and what is of especial value, a similar list of the various diabetic foods on the market.

¹ The Treatment of Diabetes Mellitus, with Observations up the Disease based on Thirteen hundred cases, by Elliott P. Joslin, M.D., M.A. 1917. Philadelphia: Lea and Febiger; Second Edition, enlarged and thoroughly reviewed. Royal 8vo., pp. 559, with illustrations. Price, \$4.50.

One of the most interesting chapters is that on the treatment of acid intoxication, and here will be found an expression of very decided views based on a very large and unique experience.

Joslin trusts to careful nursing, external warmth, clearance of the bowels by enemas, and free administration of liquids—1,000 c.c.m. within each six hours, using hot coffee, tea, thin broth or plain water, and if the fluids cannot be taken by the mouth, he gives the balance *per rectum* or subcutaneously. He absolutely condemns the use of alkali, unless it has been previously given, and then he reduces the amount steadily by 30 grammes a day. He strongly emphasizes the importance of the rôle played by fat in the production of acidosis and insists on the value of fasting in clearing up the trouble so that, if the patient has been accustomed to the fasting method of treatment, he begins or continues the fast, but if he has been upon full-diet, he takes a gramme of carbohydrate per kilogram of body weight during the 24 hours, in the form of orange juice or oatmeal gruel made with water. He urges that whichever course is adopted, it is to be followed until danger is over. The whole subject is fully discussed, and statistics given in support of his thesis. There is much to be said in favour of the views set out.

Altogether the book will well repay the time spent in reading it, and it must be looked upon as an important contribution to the literature on the treatment of this very grave condition.

Hill and Eckman's little book on the starvation (Allen) treatment of diabetes,² which runs to some 130 pages, will be found a very useful guide to the busy practitioner who wishes to know something of the principles underlying the treatment and of the methods of application of those principles. The details of treatment are shortly and concisely set out, and then the bulk of the book is occupied with a series of dietary tables, setting out various means of reaching a set caloric value with varying amounts of protein-carbohydrate and fat. Then follows a number of very useful cookery recipes and a table of food values given in percentages of protein-carbohydrate and fat with the total caloric value of each article of food.

A sample dieting of an actual case is also given, and a few typical reports of cases treated on the lines set out. The book can be recommended as a useful compend of the Allen treatment, but it is of course very sketchy and is not to be looked upon as in any way a full or complete treatise on the subject.

GONORRHOEA.

The second edition of Dr. George Luys's work of gonorrhœa and its complications³ is a masterly piece of work. The first part of the book deals with the history, dangers and aetiology. As regards the antiquity of gonorrhœa, the author goes back to the days of Moses. The oldest description of gonorrhœa dates back to the fifteenth century B.C. (Leviticus XV., 2 and 3). In no work of recent years has the author drawn such a terrible picture of the dangers of this social scourge known as gonorrhœa, which is stated to be 100 times more terrible than syphilis.

In the chapter on aetiology some new and effective methods of staining are introduced.

The importance of urethroscopy is emphasized, and many urethoscopes are figured, but the most efficient urethroscope ever invented (Wyndham Powell's aero-urethroscope) is not even mentioned. The complications are concisely dealt with. The author in this chapter becomes optimistic, and catheterizes the ejaculatory ducts. In the treatment of chronic gonorrhœa the author chiefly relies on the dilatation method, by Kollmann's dilator, which is undoubtedly the best.

The book is the most up-to-date and scientific that has yet been published.

² The Starvation Treatment of Diabetes, with a series of graduated diets, by Lewis Webb Hill, M.D., and Rena S. Eckman; 1917. Boston: W. M. Leonard. Sydney: Angus & Robertson. Third Edition. Post 8vo., pp. 134. Price, 6s.

³ A Text-Book on Gonorrhœa and its Complications, by George Luys, M.D.; Translated and Edited by Arthur Foerster, M.R.C.S., L.R.C.P.; Second Revised Edition; 1917. London: Baillière, Tindall & Cox; Royal 8vo., pp. 386, with 204 illustrations. Price, 18s. net.

Vital Statistics.

BRISBANE.

The Government Statistician's reports on the vital statistics for the fourth quarter of 1917 of Greater Brisbane have appeared in three issues of the *Queensland Government Gazette*.

There were 1,274 births, as compared with 1,286 in the corresponding quarter of 1916. This represents a net gain of 88. The birth-rate, expressed as an annual rate, is equivalent to 32.6 per 1,000 of population.

The number of deaths registered in the quarter was 573, which compares unfavourably with the corresponding figure of 533 for the fourth quarter of 1916. The death-rate is equivalent to an annual death-rate of 13.24. Of the 573 persons who died, 149 were infants under one year of age. The infantile mortality works out at 108.45 per 1,000 births. The infantile mortality rate for the corresponding quarter of 1916 was 81.72. It appears that during the quarter there were 10 twin births and there were 90 illegitimate children. During the course of the quarter 41 illegitimate children under the age of five died, including 35 under the age of one.

Concerning the causes of death the Statistician accumulates some information in a short table. Deaths attributable to diseases of the cardio-vascular system accounted for at least 97 of the 573 deaths. There were 137 from diarrhoea and enteritis, of which 121 were in infants under two years of age, 38 deaths from tuberculosis, 12 from pneumonia, nine from broncho-pneumonia, two from enteric fever, four from dysentery, one from diphtheria, one from influenza, two from pertussis, one from varicella, five from meningitis, four from encephalitis, one from simple septicaemia, eight from acute rheumatism, one from syphilis, three from acute nephritis, one from pericarditis and one from acute endocarditis. There were 41 deaths from cancer, 22 from Bright's disease, six from diabetes and one from pernicious anaemia. There were four deaths from puerperal septicaemia, one from eclampsia and four others associated with child-birth or pregnancy.

The Statistician appends a summary of the vital statistics for the year. The number of births registered in the metropolitan area was 5,612. There were 12 more males than females born. The birth-rate works out at 32.73, as compared with 32.00 for 1916.

There were 1,960 deaths registered during the year. The number of deaths in males was 296. The total number of deaths was 324 less than was registered in 1916. The death-rate is given at 11.64 per 1,000, as compared with 13.83 for 1916. There were 353 deaths of children under one year of age. The infantile mortality works out at 64.04 per 1,000 births, as compared with 83.25 for 1916.

The number of deaths due to diseases of the cardio-vascular system was 483. The next group in importance comprises the infective processes. Diarrhoea and enteritis accounted for 189 deaths, of which 160 were in infants under two years of age, and tuberculosis accounted for 132 deaths. There were 39 deaths from pneumonia, 29 from broncho-pneumonia, 18 from acute rheumatism, 17 from acute endocarditis and three from pericarditis, 17 from acute nephritis, 17 from encephalitis, 16 from syphilis, 11 from diphtheria, 11 from cerebro-spinal meningitis, 10 from simple meningitis, nine from tetanus, seven from enteric fever, six from pertussis, six from influenza, five from dysentery, five from septicaemia, two from scarlatina, two from erysipelas and one from morbilli. There were 191 deaths from malignant disease, 100 from Bright's disease, 19 from diabetes, 13 from anaemia, three from leukaemia and two from Graves's disease. There were 15 deaths from puerperal septicaemia, nine deaths which may be regarded as instances of the toxæmia of pregnancy, and 14 further deaths associated with pregnancy and child-birth.

INFECTIVE DISEASES.

The following information is contained in Bulletins Nos. 3, 4, 5 and 6 of the Quarantine Service, which were issued in February and March.

Variola.

There were no cases of small-pox reported in Australia during the period from January 18 to March 14.

In the course of three weeks ending January 19, 1918, there

were 21 deaths from variola reported in Bombay. One death occurred in Karachi, India, during the first week in February.

In the Philippine Islands there were 45 cases and five deaths at Zamboanga in the fortnight ending January 21, 1918, and one case at Manilla on January 1, 1918. Five cases of varioloid occurred at Manilla during the fortnight ending January 26, 1918.

Between December 17, 1917, and January 14, 1918, five cases of small-pox and one death occurred in the Straits Settlements. There were 29 cases and nine deaths in the Dutch East Indies recorded since the last report. A Bill of Health from New York contains reference to a case of small-pox early in January.

Plague.

The total number of cases of plague notified in India between November 18, 1917, and January 12, 1918, was 172,073, while the number of deaths in the same period amounted to 137,677.

In Java 150 cases and 148 deaths were reported between November 19 and December 31, 1917. Subsequent reports refer to the occurrence of plague at Samarang and Sourabaya. In Colombo, Ceylon, there were 34 cases between November 18, 1917, and February 9, 1918. There were seven cases and four deaths in Egypt between October 26, 1917, and February 7, 1918. In the Straits Settlements 73 cases and 64 deaths were reported from Singapore between January 13 and March 9, 1918, while eight cases and three deaths were reported in Penang from January 16 to March 5, 1918.

Cholera.

From the Dutch East Indies information has been received to the effect that cholera is present at Batavia. Bills of Health contain information to the effect that there were 15 deaths from cholera in the week ending December 29, 1917, in Calcutta, and 95 cases in the three weeks ending January 19, 1918, at Bombay.

Typhus Fever.

The following information concerning the prevalence of typhus fever is derived from the Public Health Reports of the United States Public Health Service, and covers the period from November 24, 1917, to January 18, 1918.

Place.	Cases.	Deaths.
Mexico	982	3
Egypt	499	207
Java	130	10
Russia	81	11
Greece	48	56
China	23	5
Canada	5	1
Switzerland	—	—
Algeria	2	—
Sweden	2	—
Spain	—	1
Tunis	—	1

It appears that three cases of typhus were reported in the United States during the last quarter of the year 1917.

Prosecutions under the Quarantine Act.

During the second half of 1917 five persons were prosecuted under the *Quarantine Act*. The prosecutions in two cases involved other persons, in addition to the chief person prosecuted. The offences were breaches of the berthing regulations, failure to keep all food stuffs in water-proof receptacles, going alongside vessel while the quarantine signal was hoisted, failure to report during the period of release under surveillance and, in the case of a master, not truly answering questions put to him by the Quarantine Officer, and failure to notify a case of venereal disease.

SYDNEY UNIVERSITY EXTENSION BOARD.

We have been asked to announce that a course of three illustrated lectures on astronomical subjects will be given at the University of Sydney by Professor W. E. Cooke, on April 11, 18, and 25, 1918. The titles of the three lectures are: (i.) The Moon, (ii.) Comets, and (iii.) To-night's Sky. Tickets for the course may be obtained from Messrs. Angus and Robertson, or from the Secretary of the Sydney University Extension Board, at a cost of 2s. 6d.

A series of four lectures on variation and heredity in plant life will be delivered by Professor A. Anstruther Lawson. The date of these lectures will be announced in due course.

The Medical Journal of Australia.

SATURDAY, APRIL 13, 1918.

The Repatriation Scheme.

The regulations of the Repatriation Commission, of which the Minister for Repatriation is Chairman, were issued on April 4, 1918, and came into force on April 7. Much of ground covered has little or no special medical significance, although the medical profession, as a body of educated and intelligent citizens, will study the provisions closely and with deep concern. The transference of the administrative powers from the War Councils to State Boards and Deputy Comptrollers aims at smoother and more efficient working. It remains to be seen whether the change will result in satisfactory practice. The principle of decentralization is sound, but all will depend on the capabilities of the seven members of each State Board and of the Deputy Comptrollers. There are two chapters in the scheme which have a distinct medical bearing. In the first place vocational training is to be provided for temporarily or partially incapacitated men. These men are divided into three classes for the purposes of the scheme. In the first class there are those whose incapacity is slight and who may be expected to regain normal efficiency after a short period of training. These men will be placed in ordinary workshops and factories. The second class comprises men whose incapacity renders some special preliminary training essential before they could undertake useful work in ordinary industrial establishments. These men will be offered instruction in specially designed classes. The third class embraces men who are very seriously incapacitated. As these men are not likely to become sufficiently competent to earn a living as normal workmen, they will be employed in national workshops, where they will be trained, and where they can remain in permanent employment. It thus appears that the real vocational or professional re-education will be provided in technical classes or

in the national workshops. The experience of the past three years and more teaches that, unless the system of profession re-education is co-ordinated with a well-adapted system of physical training and mental treatment, satisfactory results will not be attained. It is quite essential to regard the problem of the incapacitated man in proper perspective and not to attack it in the middle by an endeavour to patch up a man's defects without reference to the conditions preceding his discharge from the Army. It is not enough to supply the incapacitated man with technical training which will enable his hands, arms and legs to perform certain work. These men have been exposed to noxious influences which leave a profound change apart from any direct trauma in the majority of cases. Some of the injuries received need all the ingenuity that man is capable of before function can be restored. In other cases muscles can be trained to act vicariously for other muscles which have been put out of action wholly or partially. The best results can only be anticipated if the repatriation is begun as soon as the soldier leaves the battle field. We have pointed this out over and over again. There is no mention in the new scheme of any early endeavour to restore the men either mentally or physically. In the British scheme and in the French scheme there is an intimate association between the orthopaedic and neurological services and the later professional re-education schools. The patient should be given the advantages of all the skill our Australian orthopaedic surgeons possess not only after their return to the Commonwealth, but also in Europe and at sea. The treatment should be combined with a properly planned endeavour to remove the effects that war impressed upon the nervous system of the soldier. As soon as the patient's condition admits of it, physical training should be started in specially equipped laboratories or workshops attached to the orthopaedic hospitals. From these workshops, the men should pass to the special schools for vocational training. We fear that the makeshift of providing training at technical schools or colleges, or even in specially established national workshops, will only result in a moiety of restoration. Apparently the co-operation of the medical profession in vocational re-education is not being sought.

The regulations have reference to the provision of medical treatment for those who may require it after they are discharged from the Army. It is probable that Commission built up the regulations concerning the vocational training as an expedient needed for soldiers who have received maiming injuries on the field. If this assumption be correct, the provision for medical treatment to be given when required, would be the only reference in the regulations to men incapacitated from causes other than direct trauma. It is a frequent occurrence that returned soldiers find great difficulty in retaining employment when it is found for them. War has had the effect of unfitting these men for the ordinary vocations of life and has changed their mentality. Careful treatment is needed under strict supervision. This form of incapacity should occupy the attention of the Commissioners. We find that the only provision for these men is contained in the regulation dealing with employment. The Department accepts the obligation of finding sustenance until an opportunity for employment is available. If, however, a man declines the proffered employment, or if he fails to retain it, he can make a further application to the State Board. The Commission apparently has not realized how intimately disturbances of physiological processes are bound up with the question of a complete restoration of working capacity. The repatriation scheme appears to us to suffer from the fault that it starts in the middle of a large problem, and takes no account of what has gone before. The prospects of success would be better if the Department of Defence would attack the problem from the beginning, carry it logically and consistently through up to the stage of repatriation, and seek the assistance of the medical profession in each stage.

EXPERIMENTAL LEGISLATION.

There is a canon which every astute experimenter recognizes and acts upon, no matter what problem is under investigation. If, in the course of his experiments, he discovers that his machinery, his apparatus or his plan of campaign is faulty, he breaks off abruptly and starts again with fresh machinery, apparatus or plans. He will not waste time and energy in continuing experiments under conditions which

have revealed themselves to him as indifferent or faulty. The experience gained during the preliminary research may indicate to him how much of the original machinery may be retained and how much should be scrapped. To extend his trials with a view to learning more about the defects of the machinery is so unsound that no one with discernment will willingly adopt it. The Western Australian Health Act, 1915, has been in operation since July, 1916. The part dealing with the campaign against venereal diseases was admittedly experimental, and although somewhat analogous legislation has been in force in Brisbane for a few years, the Western Australian Act actually represents the first serious legislative measure to cope with this subject from the purely scientific point of view. In another column we publish the returns of the notifications received during the year 1917, from which it will be seen that the number of persons reported to be suffering from venereal disease was 1316. This number includes 282 soldiers and 1034 civilians. Of the latter 783 were males and 251 were females. In order to ascertain whether the experiment is being worked with efficient or defective machinery, it is necessary to consider the chief objects of the measure, and to seek for information as to whether these objects have been attained. The objects of the Act are twofold. In the first place it is sought to prevent the spread of the disease, and in the second to cure it wherever it is found to exist. The general measures adopted to these ends include an endeavour to place in the hands of the responsible health authority knowledge of the occurrence of the diseases, the power to enforce treatment in every case, and lastly the control of those who are infected, until they are no longer able to spread the infection. In view of the immeasurable amount of suffering, disability and disaster caused by these diseases, those who regard the problem exclusively from the point of view of the public health, would not hesitate to adopt any means which might result in the stamping out of the diseases. Public opinion and the fact that a very large section of all classes of the community is involved militate against the obvious but intensely drastic step of strict isolation until cure has been effected of all sufferers. The Act stops far short of this. It employs notification by medical practitioners

as the first measure to disclose the extent of infection. This is supported by a provision that every person is required to undergo treatment by a medical practitioner and that unqualified persons are prohibited from undertaking the treatment. In order that persons who do not voluntarily seek advice from a medical practitioner, may be placed under treatment, the Act gives the Public Health Commissioner power to require a person to submit to examination, if he has received a signed statement to the effect that the person is suffering from a venereal disease. There is a further provision rendering it a criminal offence knowingly to infect another person. Dr. R. C. Everitt Atkinson, the Commissioner of Public Health, has recognized that notification alone is incapable of revealing all the cases of infection. It is quite useless to hold out threats of punishment for not seeking treatment from a medical practitioner, unless the Commissioner has power to order a medical examination when there is reason to suspect that an infection exists. Experience has now taught him that in many cases, and especially in the cases of young girls who are not professional prostitutes, the only persons who possess reliable evidence that a girl is infected, cannot be induced to sign a statement to that effect. He has no powers under the Act as it now stands to take action in these cases, even if he has evidence practically amounting to proof that a girl is infected, unless someone with first-hand knowledge signs a statement. In the next place he has found that the children who pass through the Children's Court are not infrequently infected. Unless the parents of these children or the children themselves agree to an examination being carried out, he has no power to enforce it, and no power to enforce treatment and control. His figures for 1916 and for 1917 show that the number of males who have been notified as suffering from venereal disease is more than four times the number of females. It is obvious that the provisions of the Act fail in this essential step of disclosing the extent of infection in females. Other defects are also apparent. An adequate control of those who are capable of spreading infection, cannot be maintained as long as an interval of six weeks is allowed to elapse before the medical practitioner consulted is required to reveal the name and address of the patient who fails

to return for continued treatment. The majority of the medical practitioners in the State hold the opinion that the patients, as a rule, submit to treatment willingly, and attend when required by them. There is a class of highly dangerous persons, however, whose carelessness and want of scruples render their control essential for the welfare of the community, who seek to avoid treatment, and who evade the law as long as they can. Again, public opinion impedes the successful working of a salutary hygienic measure. If the community were sensible of their own interests they would offer no objection to personal notification by name, and to the enforcement of such treatment as might be deemed adequate by the practitioner in charge. The medical profession is anxious to take all steps necessary to stem the tide of infection. An infected person has no right to endanger others, and since the vicious cannot be trusted to obey the behests of those acting on their behalf, as little latitude as possible should be allowed them. We note that no prosecutions have taken place of persons who have knowingly infected others. It may be that a stringent enforcement of the law might alienate those whom the health authority endeavours to approach and might render the task of gaining a complete control over the disease more difficult. But when all other means fail, this provision should not be ignored, if the interests of the community are to be safeguarded.

It thus appears that the Commissioner of Public Health on whose shoulders the administration of the Act devolves, recognized that the Act had certain defects. These defects were brought to the notice of the Ministry and an amending Bill was duly drafted and introduced into the Legislative Council. Immediately it was known that it was proposed to give the Commissioner power to deal with the difficult cases of the clandestine "amateur" and others who refused to submit to treatment, a great outburst of protest issued from the Vigilance Society and from the Churches. It was stated that it would be unsafe to permit one man to order any woman to be examined on mere suspicion that she might be infected. Talk of degradation and indignity was associated with an assumption that the Act was a contagious diseases act, and that it would be administered through

the agency of the police. In these circumstances, when the Bill was referred to the Committee of the whole House on the second reading, the Honourable W. Kingsmill moved that a select committee be appointed to investigate the matter and to report to the House. We have already dealt in these columns with the findings of this select committee. The evidence of the eleven witnesses should be read by all interested in this vital subject. The experience of the Commissioner of Public Health, that of a police-woman and of a journalist who had sat at the Children's Court on seven or eight occasions for the purpose of collecting first hand information, and that of two medical practitioners, form the most striking argument conceivable in favour of the proposed amendments of the existing Act. Certain safeguards were suggested by the select committee, and these were dealt with in the Legislative Council in due course. The Bill went through its three readings, and was then sent to the Legislative Assembly on March 13. The opponents to the measure were not less loud in their protests after it had been demonstrated that the opposition was based on fears that were groundless, and on an obsession that the measure was in practice a contagious diseases act. The facts and the extreme urgency were ignored or not understood. One witness expressed it:—"The Archbishop has said, 'Let this state of things go on for five years.' I reply that I am not prepared to let this seething pool of disease go untouched any longer than is necessary." The influence of the narrow minded opposition was too great, and within a week of the first reading, the Premier shelved the Bill by taking steps to bring the session to an early close. The result of this confusion of issues has been that an essential public health provision has been brushed aside at a time when it was most needed. The venereal clauses of the Health Act have no concern with morality or immorality. Those who hold the view that preaching, precept and persuasion can lessen the amount of vice, can follow their beliefs without interference. The clauses deal with the prophylaxis of a wide-spread and dangerous group of diseases from the point of view of hygiene. It is intolerable that men and women should be allowed to interfere on sentimental grounds with a rational measure aiming at the pre-

vention of disease. We trust that the legislators of Western Australia will awaken to their responsibility to the community and lose no time next session in reviving and passing this important measure. When they have carried out their duty in this respect, perhaps they will turn their attention to the next step in the campaign and make adequate provision for the protection of imbecile children and adults, through whose agency venereal diseases are spread to a terrible extent.

THE ACTION OF GUANIDINE BASES.

For some years suggestions have been made by many investigators that some ultimate relation exists between the condition of idiopathic tetany and that of *tetania parathyreopriva*. The similarity between these conditions is not only observed in regard to the nervous symptoms and sign, but also extend to even more intimate functions. In both conditions there appears to be an increased excretion of guanidine base through the kidney. This base is a well-known convulsant poison. Its injection into the animal body gives rise to effects similar to those exhibited by animals deprived of the parathyroid glands. The symptoms of *tetania parathyreopriva* and the similar pharmacological effects of guanidine are diminished by the administration of salts of calcium. It has, indeed, been suggested that the whole of the symptoms of idiopathic tetany and of parathyroid deficiency are due to the accumulation of guanidine bases in excessive quantity in the animal organism.

The researches of Underhill and others have made us acquainted with the hypoglycæmia which follows removal of the thyro-parathyroid apparatus. The liver becomes free from glycogen and the amount of glucose in the blood is lessened. This hypoglycæmia is temporarily removed by the injection of salt of calcium. Recently a study¹ of the changes in carbohydrate metabolism following injections of guanidine bases has been made by C. K. Watanabe. A series of estimations of the quantity of glucose in the blood of rabbits has been made. The estimations of the glucose in the blood have been made previous to the injection of guanidine and at intervals of a few hours after the injection. The results show that hyperglycæmia is observed with the second and subsequent injections for a few hours after the injection of guanidine, while subsequently the condition hypoglycæmia becomes pronounced. As a rule a diminished concentration of glucose in the blood is noticed seven hours after the injection of guanidine, and this hypoglycæmia persists for about 16 hours. A series of control experiments have been performed to render it certain that the lessened concentration of glucose in the blood is not produced by a general dilution of the total solids of the blood. There seems, therefore, to be no doubt that injec-

¹ *Journ. Biol. Chemistry*, Vol. XXXIII., page 233, February, 1918.

tions of guanidine lead to a lessened concentration of glucose in the blood. In this respect the condition induced by an augmentation of the amount of guanidine in the body resembles that observed in parathyroidectomized animals. It is to be hoped that further studies of this problem will be carried out, especially in regard to the storage of glycogen in the hepatic cells.

ANTHELMINTIC MEDICATION.

The treatment of helminthiasis is often undertaken by the patient, by the chemist or by a friendly neighbour. There is a popular belief that once the fact is established that a patient is infested with worms, all that is needed is the administration of one or other of the anthelmintics. Nothing could be farther from the truth. There is much that is still unknown concerning anthelmintic medication, and there are many striking differences of opinion among those who have studied this subject carefully. The work of Heiser on infestation with hookworm and the campaign now being undertaken by the Rockefeller Foundation in Queensland and Papua, as well as in many other countries, have attracted much attention to a highly important subject. Other forms of worms present greater difficulty at the present time. Maurice C. Hall¹ has recently called attention to some principles which he has found to be involved in the endeavour to banish worms from the intestine. He adduces evidence which shows that anthelmintics are selective in their action, and that the prospects of success depend not only on the proper selection of the drug, but also on the adoption of a suitable method of giving it. In this connexion he is insistent on the necessity of a preliminary fasting, and in the case of the majority of worms, of repeated treatments. Difficulty is frequently experienced in removing all the worms infesting the intestine. This is especially true of the whipworm when it inhabits the caecum. There is frequently a risk that the anthelmintic is absorbed before it reaches the worm. This is particularly likely to take place when the drug is dissolved in alcohol. Alcohol of itself has no action on intestinal worms. If the drug is allowed to become absorbed rapidly, there is grave danger to the host, while the worm escapes without damage. He strongly advocates giving thymol and the oleo-resin of male fern in castor oil. The reason for this preference is that the anthelmintic is carried rapidly through the intestine and but little is absorbed. He has shown experimentally that male fern is more dangerous when given without a purgative than when given with one, and that the safest purgative for this purpose is castor oil. In the next place he holds the opinion that the old teaching that anthelmintics should be allowed time to act is not based on fact. In the majority of cases he gives a purgative with or soon after the anthelmintic. Another belief that he has thrown overboard is that the passage of worms is an indication for stopping treatment. He continues or repeats treatment as long as worms come away. When no more worms are removed by a properly administered dose, he concludes that freedom from infestation has been achieved.

Naval and Military.

CASUALTIES.

The 388th list of casualties, which was issued to the public on April 8, 1918, informs us that Captain Percy Alan Earnshaw has been wounded and that Captain Frank Elliott Trenoweth True has been seriously injured in an accident.

The name of Captain Hubert James Orr appeared in the 387th list under the heading of dangerously ill.

HONOURS.

The following decorations have been received by the members of the Australian Army Medical Corps:

Distinguished Service Order.

Major William Bannerman Craig.

Major William Alan Halles.

Major Harry Bertie Lee, M.C.

Major Robert Maxwell McMaster.

Bars to the Military Cross.

Captain Charles Herbert Leadman, M.C.

Captain Patrick Francis Joseph O'Shea, M.C.

Military Cross.

Captain Douglas Lewis Barlow.

Captain John Herald Balfour Brown.

Captain Stuart Galloway Gibson.

Captain Stanley Arthur Ralton.

Captain Eric William Beresford Woods.

APPOINTMENT.

Lieutenant-Colonel H. W. Bryant has been appointed President of the permanent Medical Referee Board in the No. 3 Military District.

THE FRIENDLY SOCIETIES' BILL.

The Friendly Societies' Bill, which was temporarily put aside on the defeat of the Bowser Ministry, was introduced into the Legislative Assembly of Victoria for the second reading on March 27, 1918, and passed through its various stages in both Houses. Assent was given by His Excellency the Governor on April 4, 1918. It has been announced that the Friendly Societies' Association, in response to an invitation from the Premier, have nominated Mr. S. Maugher, of the Independent Order of Rechabites, Mr. T. Crosby, of the Australian Natives' Association, Mr. J. J. Liston, of the Druids, Mr. J. Callaghan, of the Protestant Alliance Friendly Society, and Mr. Fraser, of the Sons of Temperance, to represent the Friendly Societies on the tribunal created by the Act. The Victorian Branch has refused to nominate representatives of "medical practitioners."

In reply to a question asked in the Legislative Council of New South Wales on March 14, 1918, whether the Government would take steps to have "the malady known as 'X' disease" fully investigated, the Minister for Health, the Hon. J. D. Fitzgerald, replied:

Not only the health authorities, but private physicians who are brought into contact with this disease, have been making strict investigations. I am afraid that, through circumstances which will later on be the subject of enquiry, and probably legislation, the State has lost the services of Dr. Cleland; but I realize the importance of the question, and I can assure the honourable gentleman that the Government is taking every possible step in conjunction with private investigators to obtain control of this terrible disease.

On enquiry, we have been informed that Dr. J. Burton Cleland has not resigned his position as Principal Microbiologist of the Public Health Department, New South Wales.

We have received a copy of the new edition of the Pharmacopœia of the Royal Prince Alfred Hospital, Sydney, and note that the metric system has been introduced. Unfortunately, the Imperial system is still retained and, indeed, is given the prior position. The compilers of the Adelaide Hospital Pharmacopœia have shown themselves to be more advanced than those of the Melbourne Hospital and the Melbourne Children's Hospital and the Royal Prince Alfred Hospital Pharmacopœia. No doubt the interim stage will soon pass, and in the subsequent issues of our hospital pharmacopœia the metric system will be in exclusive possession.

¹ New Orleans Medical and Surgical Journal, February, 1918.

Abstracts from Current Medical Literature.

SURGERY.

(124) War Wounds of the Knee Joint.

In a discussion on the treatment by French surgeons of war wounds of the knee joint, J. R. Judd (*Surg., Gynec., and Obstet.*, February, 1918) points out that treatment has passed through three stages; the first, a stage of conservatism; the second, one of radicalism; and the third, one of conservative intervention. War wounds of this joint are classified into those with bony lesions (which may be limited or extensive) and those without bony lesions. A vibration synovitis has been described by Makins, in which there is considerable effusion into a joint due to concussion of the limb, but without actual contact of the projectile. In the treatment of the widely different lesions, there is great divergence of opinion as to the best procedure. All agree as to the fundamental principle of early intervention for the removal of foreign bodies, but it is in the treatment of joint injuries complicated with bony lesions that opinions differ. On the one hand, arthroscopy, with removal of loose fragments, and resection for grave bony lesions only, is advocated; on the other, there are those who consider that the safest course lies in immediate subperiosteal resection with preservation of periosteum, capsule, and tendinous insertions. The use of rubber tubes traversing the joint is generally considered harmful from the point of subsequent adhesions. A new technique, however, has been evolved with excellent results by Loubat, what is called "laparotomy of the knee." This is done as soon as possible. The knee joint is opened by an U-shaped incision that divides the patellar ligament. Bony fragments are removed, the margins of the synovial wound excised, and the synovia sutured with catgut. The joint is then completely closed without drainage after the wounds of entrance and exit, as well as the track down to the synovia have been excised. A fenestrated plaster of Paris splint or a gutter splint is applied, but is removed about the fifteenth to the twentieth day, when mobilization is begun. Resection and amputation are reserved for the cases complicated with extensive bony lesions.

(125) Dichloramine-T in Infectious Wounds.

W. E. Lee and W. P. Furness give the results of their opinion of dichloramine-T in the treatment of infectious wounds (*Surg., Gynec., and Obstet.*, February, 1918). According to them, Dakin's solution has certain inherent faults. (1) It is unstable; (2) If diluted the slightest amount below its usual strength (0.48%) its germi-

cidal efficiency is impaired greatly; (3) The active chlorine is used up so quickly that it is necessary to renew it every two hours day and night. To overcome these defects Carrel and Deheley developed a "beautiful and complicated" technique with which they were able to obtain wonderful results. Others, however, have not been able to obtain these results, probably because of flaws in their technique. It is pointed out that the Carrel technique requires the doing away with drainage, so that the wounds become basins for retaining the solution. Should this hydraulic system for any reason break down, then the wounds will become basins of pus, and unfortunate results will follow. A search was therefore started for a more suitable germicide, and this has been found in dichloramine-T. Dissolved in chlorinated eucalyptol, it can be used in strengths from 5% to 20%, and its action can be so prolonged that a mass of germicide is active for 18 to 22 hours, which is equal to that given by Dakin's solution during the first 7 to 15 minutes. The clumsy Carrel technique is thus dispensed with. The authors have records of over six thousand civil, and twelve hundred war, cases, in which it has been used, the latter from the No. 10 U.S.A. Base Hospital. The conclusions arrived at are that equally good results can be obtained from dichloramine-T as from Dakin's fluid used with the correct technique. Skin irritation will not occur if the absolute minimum is used in the way of gauze; dressings are thus economized. Further, this antiseptic has no disintegrating effect on catgut ligatures, such as Dakin's solution possesses. Secondary, haemorrhage was no uncommon experience with Dakin's fluid in the hands of the authors at American Ambulance in Paris, due to this disintegration. Lastly, dichloramine-T has most valuable deodorant powers.

(126) Fat Embolism Following Bone Trauma.

G. T. Caldwell and H. L. Huber (*Surg., Gyn., and Obstet.*, December, 1917) give the results of an experimental study of the production and prevention of fat embolism. Fritzsche believed that the lymphatics were the chief carriers of the fat in cases in which jarring of the long bones was unaccompanied by haemorrhages into the marrow, but that when there were haemorrhages into the marrow, fat embolism arose by way of the veins. Ribbert emphasized the importance of simple jarring as a cause of embolism, and suggested that for this reason the chisel should give place to the saw in surgery. The authors themselves used rabbits which, after being narcotized with chloral hydrate, were anaesthetized with ether. The operations consisted of striking numerous slight blows on the front of the tibia with a percussion hammer, of boring through the tibia and destroying the marrow with wires, and of crushing the tibia with a pipe wrench

after section of the sciatic nerve. The animals were usually allowed to live five hours, and were then asphyxiated, sections being taken of different parts of their lungs. They found that Eschmarch's constrictors placed on the legs before crushing the tibia and removed two hours after, distinctly lessened the amount of fat in the lungs, and that even this amount depended mainly on the activity of the animals after removal of the constrictor. Rabbits narcotized during the entire experiment, developed very little fat embolism, and the use of the chisel in taking tibial grafts increased but very slightly the amount of fat in the circulation. In the spinal part of the Albee bone graft operation, however, there was a greater tendency to fat embolism than in the tibial part of the procedure.

(127) Ossifying Myositis.

In the *Surgical Clinics* for December, 1917, Dean Lewis reports a case of *myositis ossificans* occurring in an incised wound, seven weeks after a gastro-enterostomy performed for duodenal ulcer. The post-operative course of the case was smooth, save that the patient had fever for four days, which was considered due to a slight bronchitis. There was no inflammatory reaction in the wound, and the patient left hospital on the thirteenth day. A week later tenderness was felt in the scar; at the end of seven weeks a mass having the consistency of bone, was palpated and X-rays revealed a distinct shadow. Lewis points out that circumscribed myositis may be divided etiologically, into traumatic cases, non-traumatic, and those associated with defect or disease of the nervous system. The majority of the circumscribed cases associated with injury, follow a single severe injury, especially where a blunt force is associated with laceration of muscle and haematoma formation. According to Kuttner in 1910, only five cases had been reported in which this condition had followed the use of a sharp instrument or in a clean incised wound. Three cases had been reported in which bone had developed in a laparotomy wound. In Lewis's case the incision passed through the *linea transversae*, and he suggests that osteoblasts may have remained latent in the lines "which represent the extension forward of their ribs."

(128) Tuberculosis of the Thyroid.

In *Surgery, Gynecology and Obstetrics* of June, 1917, Roscoe Mosiman reports nine cases of tuberculosis of the thyroid from the Crile clinic. Previous investigators had so rarely noted tuberculosis of this gland that it became credited with a supposed immunity against the tubercle bacillus. Experiments, however, have shown that the thyroid in rabbits can be infected, if tubercle bacilli are injected into the carotid artery. Torri, by injecting an emulsion of these organisms into the thyroid artery, infected the corresponding lobe. He failed to demonstrate the bacilli in the colloid mate-

rial of the gland ten days after injection, so that he concluded that colloid destroyed these organisms. Shimo-daira concluded that the thyroid could be infected by direct injection, just like the spleen, kidney or testicle, but that it was less susceptible than these organs. Of Mosiman's patients the youngest was 18 and the oldest 60, and the average duration of the goitre was 18 months. In all but two the diagnosis was exophthalmic goitre, and in no case was tuberculosis considered, or even suspected from examination of the gross specimen. Five of the cases showed diffuse and more or less symmetrical enlargement of both lobes, while in four there was a tumour. For the absolute diagnosis of these cases it is necessary to demonstrate the tubercle bacillus, but the histological picture was taken as sufficiently typical to justify an assumption of the presence of the disease. Mosiman follows Ruppaner's division of tuberculous thyroids into interfollicular and intrafollicular types, the former being by much the more common. It is doubtful if there is a true primary tuberculosis of the thyroid; the majority of the cases are secondary to a focus elsewhere. The nine cases reported represent a tuberculous involvement in less than 1% of the operative material removed in the Chile clinic.

GYNAECOLOGY AND OBSTETRICS.

(129) Exogenous Infection with Colon Bacillus.

E. P. Davis (*Surg. Gynec. and Obstet.*, February, 1918), after reviewing the methods of treatment usually adopted in infection of the kidney with *bacillus coli communis*, viz., posture, drugs, vaccines, catheterization of the ureters and draining the pelvis of the kidney by nephrotomy, and after quoting several cases of colon bacillus pyelitis of pregnancy benefited after failure by medicinal means, by the two local procedures referred to, proceeds to give his observations on cases in which infection with *bacillus coli communis* attacking the appendix, the colon and surrounding tissue has complicated pregnancy or the puerperal state. The symptoms of this condition are often obscure, and the diagnosis between appendicitis and infection of the right kidney and syphilis may be impossible before the abdomen is opened. Leucocytosis, widely distributed tenderness, beginning paresis of the intestine without signs of active peritonitis point strongly to colon bacillus infection. When this condition occurs in puerperal patients the diagnosis from septic infection is usually made difficult. A point of difference is the non-suppression of lochia. The treatment consists of abdominal section, removal of the appendix and free drainage. The author quotes several cases in which he has operated, and describes the peculiar inflammation and distension of the caecum and once of the whole large intestine, with non-perforative ulcer-

ation. He regards it as of especial importance for the welfare of pregnant women and their children that *bacillus coli communis* infection be promptly recognized and treated and not confused with puerperal sepsis during this period.

(130) Caesarean Section.

J. C. Jefferson (*Practit.*, December, 1917) describes the technique adopted at the Rockdale Infirmary for Caesarean section. He divides the patients into two groups: (1) Those in whom there has been no previous interference; and (2) those in whom previous attempts to deliver have been made. These he considers to be probably infected. For Group 1 the operation area is covered with two layers of sterile batiste, towels and abdominal sheets. Pituitary extract (1 c.c.m.) is given, the uterus is incised as it lies in the abdominal cavity, its contents are rapidly extracted, and it is then lifted out of the wound and grasped firmly round its base by an assistant, while its interior is carefully wiped out. He regards as an essential step in the operation the stretching of the cervical canal to provide free outlet for the lochia. He accomplishes this by inserting two fingers, and changes his gloves before closing the uterine incision with interrupted catgut sutures. In the second group a preliminary vaginal douche is given, the abdominal incision is made considerably longer, so that the uterus can at once be lifted out of the abdominal cavity. The intestines are then packed off with gauze. One cubic centimetre of pituitary extract is given, as before; the uterus is incised and emptied. The interior of the uterus and the edges of the uterine wall are well swabbed with iodine. Gloves are then changed, and the uterine incision is closed. The gloves are then changed for the second time before closing the abdominal cavity. Though the procedures may seem elaborate in detail, it is, in his opinion, only by strict attention to detail that disappointing failures can be avoided.

(131) Retroversed Fixed Uterus

Alfred Smith (*Dublin Journ. Med. Science*, April, 1917) discusses the operative treatment for fixed backward displacement of the uterus. After pointing out the uselessness of old-time treatment by ichthyol and glycerine plugs, he discusses Dr. Gilliam's operation, which he did until he found that the end results were not satisfactory, as many of his patients complained of dragging pains referred to the suspension points in the recti muscles. At first he was of the opinion that his technique was at fault, but later he found that all cases could not be treated alike, as the behaviour of the uterus after the separation of the adhesions was different in each case; some uteri came up easily showing a certain amount of relaxation of their supports, others did not come up, and required a considerable degree of force to draw them into position. He thus deals with two groups: (a) uteri with relaxed supports, (b) uteri with unrelaxed sup-

ports. For treatment he recommends in Group A that the uterus be suspended or fixed according as the patient is capable of bearing children or past the climacteric. He recognizes three types of Group B: (1) where the uterus righted itself automatically, (2) where manual replacement was necessary, and (3) where, owing to thickening and shortening of utero-sacral ligaments, the uterus could not be brought into the normal position of anteflexion. The uterus in types 1 and 2 has little tendency to fall back, and suspension or fixation is therefore unnecessary. The author admits that the treatment of type 3 baffles him, and he merely frees the uterus from its entanglements, straightens out the tubes, releases the ovaries where necessary and leaves the rest to nature. He considers that it would be hopeless to attempt suspension or fixation. He concludes by asserting that he has made these observations in the hope of interesting surgeons in determining the limitations of suspension and fixation, and of putting the operative treatment of fixed displacements on a scientific footing.

(132) Toxæmias of Late Pregnancy.

A. C. Beck (*Med. Times*, February, 1918), in a short paper, indicates how to differentiate between the toxæmias which occur late in pregnancy with special reference to the prognosis in future pregnancies. After describing the usual clinical picture presented, he asserts that there are two distinct varieties of this condition. In one future pregnancies occur without any sign of recurrence, and in the other the symptoms recur both earlier and with greater severity. Fatal cases likewise revealed two different pathological pictures. One invariably was characterized by a typical lesion in the liver, which consisted of a perilobular thrombosis with necrosis of the periphery of the lobule. The kidney involvement was more or less transient and showed nothing more than congestion and cloudy swelling. The name of hepatic toxæmia was given to this variety. In the second group typical findings of nephritis were noted, and it was therefore called nephritic toxæmia. These latter cases recur, and the former do not. Clinically in the hepatic cases symptoms come on suddenly, are marked and rapidly increase in severity, and following the subsidence, the blood pressure and urine rapidly return to normal. Nephritic toxæmia is more gradual in its course, and is frequently preceded by a history of nephritis. Following delivery, the blood pressure and urine gradually approach normal, but continue to show evidence of permanent renal injury. He records histories of several cases illustrating each group. He summarizes that: (1) All late toxæmias should be studied carefully in order that proper advice concerning future pregnancies may be given. (2) Hepatic toxæmia is followed by no great danger of recurrence in future pregnancy. (3) Nephritic toxæmia always recurs and all patients should be advised to avoid becoming pregnant.

British Medical Association News.

SCIENTIFIC.

A meeting of the Queensland Branch was held at the B.M.A. Rooms, Adelaide Street, Brisbane, on February 1, 1918, Dr. Espie Dods, the President, in the chair.

Dr. L. P. Winterbotham read the notes of a case of congenital dislocation of the knee. He pointed out that dislocation of the knee, occurring either *in utero* or during the birth, was a rare accident. In his case it could be definitely shown that very little external force had been used. The baby, an eight month girl, was born on January 18, 1918, and was small in size, weighing about 2,270 grammes. The mother had had two children, the issue of a previous marriage. Both were reputed to be healthy. The patient was the fourth child. The mother's pelvis was normal and roomy, and she stated that the previous labours had been easy. By a previous marriage the father had had eight healthy children. One child, however, had a marked degree of cleft palate and hare-lip, and the father himself had an inguinal hernia. As far as was known, there had been no case of deformity in the past generations of either parent. During the pregnancy the mother had suffered considerable discomfort and pain, especially in the right iliac region. She had noted that the foetal movements were very feeble. The labour started on January 11, but the pains were not severe. On the 13th, Dr. Winterbotham was sent for, and discovered that both knees were presenting through a fully dilated os. The legs were bent backwards at an angle of fully 60° on the thighs. He ruptured the membrane, and, with a little careful manipulation, was able to get both feet down. The subsequent delivery was easy.

On examining the baby he found that both tibiae had been dislocated forwards and that the articular surfaces of the femora could be distinctly felt behind the heads of the tibiae. They showed a tendency to remain in that position and, after reduction, to return to it. The leg permitted of extension at the knee joint at about 60° past the straight line. The dislocation was easily reduced and the leg straightened. Flexion, however, was impossible. The condition had improved somewhat since the birth, and the forward movement had become less free. Flexions, however, still remained impossible. Dr. Winterbotham raised the question whether the deformity had not existed for some time *in utero*, because of the permanence of the deformity and the unnatural and restricted immobility of the joint. There were no signs of recent injury, such as swelling or bruising, nor was there any apparent pain caused by the manipulation to effect reduction.

Dr. T. H. R. Mathewson expressed the opinion that the dislocation was a developmental error.

Dr. M. Patterson exhibited three skiagrams illustrating oesophageal spasm. A bismuth meal had been given and the skiagrams revealed a spasmodic contraction at the lower end of the oesophagus.

In reply to Dr. G. W. F. Paul, Dr. Patterson stated that the spasm was, presumably, nervous. No other cause had been discovered.

Dr. J. Lockhart Gibson exhibited the eye of a young child. The eye had been removed that afternoon for glioma of the retina. He demonstrated the peculiar and pathognomonic reflex from behind the lens, as seen through the pupil. The growth was beginning to fill the eyeball; the yellowish-white reflex was produced close behind the lens. Practitioners not engaged in eye work should be able to recognize this reflex, because failure to recognize it early enough meant the death of the child. In his own case it had been recognized too late. The child had been sent to the Children's Hospital on the previous day with a diagnosis of cataract. After the eye had been removed, deposits had been found in the orbit which had therefore been cleared of its contents. The outlook was most unhopeful. The growth was almost sure to return.

Dr. R. Graham Brown, in discussing the question of malignancy, stated that the condition should not be called glioma. It was, in fact, an epithelioma of the retina. There was still difference of opinion concerning the pathology of the condition.

The Honorary Secretary read a paper by Dr. T. H. Morgan entitled "Some Notes on Abdominal Cases" (see page 300).

Dr. L. N. McKillop disagreed with Dr. Morgan in regard to his diagnosis of the second case as *hernia en glissade*. He thought it was a sliding hernia. He considered that lavage was a dangerous treatment for gastric ulcer. At times the stitches cut through the mucous membrane of the stomach and allowed haemorrhage to occur.

Dr. C. A. Thelander referred to a case in which a large mass was found in the abdomen at the operation. The mass was thought to be malignant. The patient subsequently passed material gall stones, and at the time of speaking was recovering.

A meeting of the Queensland Branch was held at the B.M.A. Rooms, Adelaide Street, Brisbane, on March 1, 1918, Dr. Espie Dods, the President, in the chair.

Dr. T. H. R. Mathewson exhibited two children, one of whom was suffering from congenital syphilis and the other from cerebral tumour. A discussion followed in regard to the diagnosis of the second case.

Dr. Alfred Sutton demonstrated the skull of an adult obtained from abroad. The skull had a clean cut trephine hole over the left frontal region. An interesting discussion took place as to whether the operation had been performed before or after death. Unfortunately, there was not enough evidence to enable the members to arrive at a reasoned decision. It was agreed that the operation had been performed many years ago. He also showed an Egyptian stone axe, which he had discovered at Mena Camp in 1914. The axe weighed 7 kilograms, was faced in a manner similar to the stone axes of the Australian aborigines and had an annular depression at the blunt end, which had evidently been made for the purpose of the easy attachment to a haft. It was surmised that it was a battle axe and that it dated from the time before the pyramids.

In the third place, he demonstrated a perfect stone specimen of the Phallus, beautifully but simply carved. This specimen had been found in 1915 on the Gallipoli Peninsula, on the banks of a small stream near the Australian Casualty Clearing Station.

Dr. W. Wallace Hoare read a paper on some points in the operative technique and after-treatment of senile cataract. He showed two patients who had been operated upon for this condition (see page 297).

Dr. W. F. Taylor thanked Dr. Hoare for his paper. He regarded the cosmetic results obtained in the cases shown as good. He thought that irrigation of the conjunctival sac was quite sufficient if care were exercised in regard to the upper fornix. He held that retraction interfered with the operator. He preferred to use a speculum and to lift it slightly, so as to avoid pressure on the eye-ball. Immature cataracts in old people were difficult cases to deal with. When needling was necessary, the vitreous fluid escaped easily.

Dr. R. Graham Brown congratulated Dr. Hoare on the results he had obtained. His objection to simple extraction was that there was sometimes a prolapse of the iris after two or three days. Dr. Hoare had overcome this danger by performing a small peripheral iridectomy.

Dr. J. Espie Dods complimented Dr. Hoare on the excellence of his results.

In his reply, Dr. Hoare stated that the difficulty of the vitreous escaping could be overcome by the avoidance of the use of the speculum and the adoption of the use of retractors. In cataract extraction it was most difficult to exercise care and judgement in regard to the amount of pressure to be applied in expelling the lens.

The undermentioned have been nominated for election as members of the New South Wales Branch:—

James Adolph Gruen, M.B., 1917 (Univ. Sydney), "Kelinvin," 77 Ramsay Street, Haberfield.

Walter Francis Stewart Yeates, M.B., 1915 (Univ. Sydney), Ballina.

Charles Alexander Crothers, M.B., 1909 (Univ. Sydney), Newcastle.

Public Health.

THE HEALTH OF AUSTRALIA.

Infective Diseases Notified in Australia during the Quarter ending December, 1917.

	New South Wales.	Victoria.	Queensland.	S. Australia.	W. Australia.	Tasmania.	Commonwealth.
	Cs. Dths.	Cs. Dths.	Cs. Dths.	Cs. Dths.	Cs. Dths.	Cs. Dths.	Cs. ³ Dths.
Enteric Fever	182	19	100	7	155	7	32
Scarlatina	240	4	651	14	56	0	52
Diphtheria	806	30	839	31	335	15	244
Pulmonary Tuberculosis	1282	243	401	240	120	76	154
Cerebro-spinal Meningitis	29	13	26	12	6	2	6
Poliomyelitis	2	1	15	2	2	0	0
Malaria	3	2	0	0	7	11	0
Puerperal Fever	—	16	0	11	5	5	4
Septicæmia, Pyæmæia and Sapræmæia	—	10	0	9	—	3	3
Bilharziosis	—	0	—	0	3	0	0
Morbilli	—	12	—	3	—	0	22
Pertussis	—	31	—	22	—	12	90
Ophthalmia Neonatorum	—	0	0	1	—	0	0
Erysipelas	—	5	0	2	23	0	20
Beri-Beri	—	1	—	0	—	1	22
Ankylostomiasis	—	0	—	0	9	0	0
Variola	—	12	0	0	0	0	0
Dysentery	—	—	—	—	1	—	—
Favus	—	—	0	—	0	0	12
Low Fever	—	0	—	0	—	0	0

¹ Notifiable only in portion of State.² Including one death in Northern Territory.³ The total number of cases notified is not given of those diseases which are not notifiable in all the States.⁴ From the returns it is not clear how many of the septicæmia or sапрæмæia cases were puerperal.

Infective Diseases Notified in Australia during the year 1917.

	New South Wales.	Victoria.	Queensland.	S. Australia.	W. Australia.	Tasmania.	Commonwealth.
	Cs. Dths.	Cs. Dths.	Cs. Dths.	Cs. Dths.	Cs. Dths.	Cs. Dths.	Cs. ³ Dths.
Enteric Fever	1056	97	511	62	583	238	29
Scarlatina	2062	27	1994	33	504	3	236
Diphtheria	5299	244	4092	154	1649	78	1257
Pulmonary Tuberculosis	1241	1012	1562	907	470	311	547
Cerebro-spinal Meningitis	186	85	157	76	100	54	46
Poliomyelitis	14	4	33	4	24	4	0
Malaria	19	6	0	0	106	37	1
Puerperal Fever	—	116	—	54	22	32	21
Septicæmia and Pyæmæia	—	59	0	45	—	13	9
Bilharziosis	—	0	—	0	3	0	0
Morbilli	—	26	0	15	—	14	291
Pertussis	—	142	—	67	—	24	770
Ophthalmia Neonatorum	—	0	0	1	—	0	0
Erysipelas	—	30	0	8	122	5	94
Beri-Beri	—	2	—	0	—	2	52
Ankylostomiasis	—	0	—	0	89	3	0
Variola	—	118	0	0	0	0	0
Anthrax	—	0	0	0	—	0	0
Dysentery	—	—	—	—	1	—	—
Low Fever	—	—	—	—	—	—	1
Favus	—	—	—	—	—	48	—

¹ Notifiable only in portion of State.² The total number of cases notified is not given of those diseases which are not notifiable in all the States.³ Including four deaths in the Northern Territory.⁴ Including two deaths in the Northern Territory.⁵ Including one death in the Northern Territory.

NEW SOUTH WALES.

The following notifications have been received by the Department of Public Health, New South Wales, during the week ending March 30, 1918:—

Metropolitan	Hunter River	Rest	Total.
Combined District.	Combined District.	State.	
Cs. Dths.	Cs. Dths.	Cs. Dths.	Cs. Dths.
Enteric Fever	5	0	4
Scarlatina	9	0	0
Diphtheria	47	0	11

*Pul. Tuberculosis 17
C'bro-Spl. Menin. 0
Poliomyelitis 0

* Notifiable only in the Metropolitan and Hunter River Districts, and since October 2, 1916, in the Blue Mountain Shire and Katoomba Municipality.

VICTORIA.

The following notifications have been received by the Department of Public Health, Victoria, during the week ending March 31, 1918:—

Metropo- litan.	Rest of State.	Total.
Cs. Dths.	Cs. Dths.	Cs. Dths.
Enteric Fever	3	1
Scarlatina	37	0
Diphtheria	68	1
Pulmonary Tuberculosis	25	11
C'bro-Spl. Meningitis	0	1
Poliomyelitis	6	8

QUEENSLAND.

The following notifications have been received by the Department of Public Health, Queensland, during the week ending March 30, 1918:—

Disease.	No. of Cases.
Enteric Fever	17
Scarlatina	5
Diphtheria	44
Pulmonary Tuberculosis	5
Cerebro-spinal Meningitis	3
Erysipelas	2

SOUTH AUSTRALIA.

The following notifications have been received by the Central Board of Health, Adelaide, during the week ending March 23, 1918:—

	Adelaide.	Rest of State.	Totals.
	Co. Dths.	Co. Dths.	Co. Dths.
Enteric Fever	1 0 ..	1 0 ..	2 0
Scarlatina	0 1 ..	7 0 ..	7 1
Diphtheria	1 1 ..	23 0 ..	24 1
Pulmonary Tuberculosis	0 0 ..	3 2 ..	3 2
Erysipelas	0 0 ..	2 1 ..	2 1
Pertussis	0 0 ..	1 0 ..	1 0

VENEREAL DISEASES IN WESTERN AUSTRALIA.

The following information concerning the distribution of

venerereal diseases, as revealed by notification, has been issued to us by the Department of Public Health of Western Australia.

VENEREAL DISEASE.

Twelve Months ended 31st December, 1917.

Table I.—Summary of Notifications.

Diseases.	Males.	Civilians.	Total	Total Cases.	Total Notified.
	Civilians.	Military.	Total Males.	Females.	Both Sexes Received.
Syphilis—					
Primary	56	38	94	15	109 .. 137
Secondary	41	12	53	41	94 .. 129
Tertiary	35	—	35	20	55 .. 116
Congenital	13	—	13	8	21 .. 28
Total Syphilis	145	50	195	84	279 .. 410
Gonorrhœa	603	220	823	141	964 .. 1231
Chancroid	27	12	39	7	46 .. 59
Granuloma	8	—	8	19	27 .. 28
Grand Total	783	282	1065	251	1316 .. 1728

Table II.—Table Showing Age and Sex of Cases Notified.

Disease.	Under	10 and	20 and	30 and	40 and	50 and	60 and	Age Not Stated.	All Ages.	Total.
	10 Years. M. F.	Under 20. M. F.	Under 30. M. F.	Under 40. M. F.	Under 50. M. F.	Under 60. M. F.	Over. M. F.			
Syphilis—										
Primary	..	—	5 4 ..	45 6 ..	31 2 ..	8 1 ..	3 — ..	2 — ..	2 ..	94 15 .. 109
Secondary	..	—	3 6 ..	20 19 ..	15 9 ..	14 6 ..	1 1 ..	— ..	— ..	53 41 .. 94
Tertiary	..	—	— ..	— ..	3 4 ..	15 7 ..	6 5 ..	9 4 ..	2 — ..	35 20 .. 55
Congenital	..	10 7 ..	3 1 ..	— ..	— ..	— ..	— ..	— ..	— ..	13 8 .. 21
Total Syphilis	10 7 ..	11 11 ..	68 29 ..	61 18 ..	28 12 ..	13 5 ..	4 — ..	2 ..	195 84 ..	279
Gonorrhœa	..	4 30 ..	75 26 ..	386 61 ..	204 16 ..	103 3 ..	43 4 ..	8 ..	— ..	823 141 .. 964
Chancroid	..	—	— ..	4 2 ..	20 3 ..	5 1 ..	5 1 ..	4 ..	— ..	39 7 .. 46
Granuloma	..	—	— ..	— ..	2 ..	1 2 ..	— ..	1 ..	— ..	6 14 .. 8 19 .. 27
Grand Total	..	14 37 ..	90 41 ..	475 95 ..	270 36 ..	137 16 ..	60 9 ..	13 ..	6 17 ..	1065 251 .. 1316

MEDICAL INSPECTION OF SCHOOLS IN NEW ZEALAND.

The Medical Inspectors of Schools have presented to both Houses of Parliament their report on the medical inspection of schools and school children in New Zealand for the year ending December 31, 1916. The report is forwarded through the Director of Education. Medical inspection of schools in New Zealand was inaugurated in 1912 with a staff of four doctors. Since that time two additional doctors and seven school nurses have been appointed. Over 100,000 children have been examined and notifications have been sent out to parents, telling them of the defects discovered. The medical inspectors say that the same conditions are observed in New Zealand as in other countries. They find that one-half to two-thirds of the children inspected are in need of the attention of a dentist, oculist or physician. The schools are not filled with physical wrecks, but many children enjoy less than their possible measure of good health. The physical defects of school children are subnormal nutrition, dental caries, defective eyesight and hearing, physical deformities as flat chest, flat feet and spinal curvature, and mental retardation or deficiency.

Nutrition has been found satisfactory in about 90% of the children. A comparison of the heights and weights of British

and New Zealand children of the same age is in favour of the colonial, who is taller and heavier. Cases of bad nutrition are common in children from the slum areas of cities and from remote country districts. In the struggling country districts the houses are overcrowded and insanitary, food is monotonous in kind and often badly cooked, while mothers and children are overworked. Country children are often sent to distant schools after an insufficient breakfast. The supervision of lunch, ensuring rest during the meal, together with the provision of hot cocoa at cost price, has led to an increase in both the heights and the weights of the scholars. The medical inspectors protest against the employment of school boys after school hours or upon Saturdays. They assert that these children are physically and mentally weary during school hours. They believe that hours spent in practising music, in pouring over books or in attending the cinematograph should be spent in healthy play outside or in sound sleep in bed.

Dental caries is widespread among the children of New Zealand. As the teeth are examined in every child, the medical inspectors can notify parents when the teeth require attention. Thousands of children have been taken to the dentist in consequence. On re-examination of a school there has been a noticeable increase in the number of children who have had dental attention and have acquired "artificially

"sound" teeth. In school the children receive instruction on the value of sound teeth and on the importance of keeping them clean. The "clean mouth" habit must be part of the child's life. The question of "tooth-brush drill" is being reconsidered by the medical inspectors. Dental hospitals have been of great assistance in large centres of population. The medical inspectors are of opinion that special dental clinics for school children should be established, and that it might be possible to arrange for special contract rates with local dentists in country districts. They are also strongly of opinion that more must be done in the way of the preventive treatment of dental caries. They believe the problem to be one of diet and of cleanliness.

The adequate treatment of defects of eyesight and hearing is regarded as a matter of urgency. From 7% to 10% of the children have defective vision. The inspectors notify children as possessed of defective vision when the children can read less than $\frac{1}{2}$, in each eye with Snellen's test types. It has been noticed that the percentage of defective eyesight rises steadily from standard to standard throughout a school. Thus the number of children with defective sight is greater in the upper classes. The treatment of defective vision is regarded as less satisfactory than the treatment of any other defect. This statement probably does not include defective hearing, which is notoriously difficult to remedy. In country districts the child is unable to get any skilled treatment and is left in the hands of the spectacle vendor. It cannot be too strongly impressed upon the community that none but medical practitioners practising as ophthalmologists, should treat defects in the sight of children. Owing to the small number of ophthalmic surgeons and the high fees to which such specialists are entitled, the child is forced to choose between no treatment at all and treatment by an unqualified optician. There seems to the school inspectors at present no remedy, as it is impossible to send large numbers of children to the hospitals. It might be possible for an arrangement to be made between the oculists and the Department of Education for the establishment of children's clinics in connexion with the out-patient departments of the hospitals. So far no scheme has presented itself to the medical inspectors for the country children.

Amongst the school children there exists a large amount of physical asymmetry. Postural defects are common. The "fatigue" posture is frequently seen, and the child sits with shoulders drooping forward, chest contracted, abdominal muscles lax and head thrown to the front. The inspectors say that it is useless to tell the children to sit erect. They are unable to do so. They need physical instruction so that good posture becomes habitual. The defects have been traced to malnutrition, adenoids, anaemia, defective vision and overwork. Long hours spent seated at the desk, contribute to production of physical deformities. Seats without backs are still common in the schools. Where these seats exist, deformities are found more often than when seats with backs are used. Bad lighting often accounts for a bad position. The medical inspectors have roughly grouped all children into four groups in relation to physical development. These groups comprise: (a) well-nourished children without any deformity, (b) well-nourished children with a physical deformity as faulty posture, drooping shoulders or faulty carriage, (c) poorly nourished children with some deformity, and (d) poorly nourished children in whom the condition of debility or anaemia is more important than the existence of any malformation. It is recommended to combat these evils that every facility be given teachers to become expert in giving physical instruction by means of vacation training-camps, refresher courses and voluntary evening classes under the Physical Instructor of the district, that the students in the training colleges receive more instruction in this kind of teaching, that the Physical Instructors, being limited in number, concentrate their efforts on training teachers rather than on the school classes, that more time be allotted to physical work in the syllabus of courses, that recognition be accorded to teachers who excel in teaching physical exercises and that the quality of this instruction be considered in the grading of teachers. It is also suggested that swimming be taught where facilities are available and that teachers encourage children to wear suitable clothing for physical instruction. Where considerable numbers of children with defects are found in a school, the medical inspectors form a "corrective

class" which receives additional instruction from a competent teacher.

In regard to children with mental defects, the medical inspectors note that there are few feeble-minded children in the schools. Children who are dull or backward constitute about 4% of those in attendance. It is suggested that these backward children might receive education, either in a special class, containing a limited number, so that each child can have individual tuition, and can be taught according to a special curriculum containing much manual work or, in the four large centres of population, in special schools.

In respect to school hygiene, the medical inspectors draw attention to overcrowding, defective lighting, insufficient ventilation and lack of proper warming appliances in different schools. Some remarks are offered about open-air schools and the provision of adequate playing ground.

An appendix to the report contains copies of four circulars issued by the medical inspectors of schools. These circulars deal with decayed teeth in children, contagious skin-diseases in school children, care of the hair and suggestions to parents about baths, food, teeth and clothing. While the report as a whole serves to show the useful and skilful work of the medical inspectors, these circulars contain statements which can only be described as extravagant and unjustifiable. When such circulars are prepared for distribution broadcast, great care should be taken to ensure that the information is based upon accurate medical knowledge. One-fourth of the circular on decayed teeth appears under the heading "decayed teeth cause ill-health." The circular states—

(1) Bad teeth can give rise to such diseases as blood-poisoning, consumption, pneumonia, diphtheria, rheumatism and many others, because:

(a) Disease germs multiply rapidly in a decayed tooth. The minute germs of the diseases mentioned may be lodged there and multiply by the thousands in a few hours.

(b) Disease germs can enter the body through a decayed tooth. The decayed spot communicates with minute vessels that enter the tissues of the body. When the disease-germs enter the body they give rise to the corresponding disease.

(2) Bad teeth cause stomach troubles, because poisonous material and germs are swallowed with every mouthful of food. This causes poor digestion, bad breath, poor general health and liability to illness.

(3) Bad teeth render chewing difficult or impossible, and food which is not thoroughly chewed and mixed with the saliva causes indigestion and constipation.

(4) Bad teeth cause toothache, and chronic toothache makes children nervous and irritable.

It has been shown by K. Goadby that pathogenic organisms such as *bacillus tuberculosis*, *b. diphtheriae*, and the pneumococcus do not occur in the cavities of decayed teeth. They certainly do not "multiply by the thousands in a few hours" in this situation. Medical literature contains no accounts of the stomach troubles produced by the poisonous material and the germs swallowed. The hydrochloric acid in the stomach will act as an efficient antiseptic for such germs. It is also probable that gumboils and facial abscesses form the most frequent conditions of ill-health due to decayed teeth. Surely they deserve mention. At the conclusion of the circular it is stated: "Remember, where teeth are bad a child swallows poison with every mouthful of food." This seems gross exaggeration. In the circular dealing with the care of the hair it is stated that unclean condition of the head due to lice "should never be neglected, as it may lead to the formation of scabs and sores on the head and enlarged glands in the neck, sometimes resulting in abscesses in the neck and even tuberculosis." While it is impossible to deny that a tubercular infection may have resulted from sores on the head, the addition of the words "and even tuberculosis" appears only of use to scare the ignorant. The inspectors, who are ladies, are no doubt entitled to their opinion that a belt is better than braces as suitable clothing for boys, but the inclusion of such directions in their suggestions to parents will bring discredit on their useful information. It is hoped that these circulars will be revised freely when it is necessary to print them again.

Hospitals.

NEWCASTLE HOSPITAL.

The annual report of the Newcastle Hospital for the year 1917, which was presented at the annual general meeting on March 27, 1918, has been published in book form.

The eastern portion of the northern wing of the new Hospital was completed towards the end of 1916, and was brought into use, together with the western section, during the course of the year under review. This wing is constructed for the accommodation of 146 patients. At the beginning of the year there were 100 beds available and at the end of the year there were 130 for ordinary patients and 15 for patients suffering from infective diseases. It is stated that the building of the central or administrative block has not been proceeded with. The delay is stated to have been due to want of funds. The Board of Directors state that no little inconvenience was caused by this delay.

On the first day of the year there were 92 patients in the Hospital. During the course of the year 1,390 were admitted and at the end of the year there were still 116 under treatment. The number of those discharged was 1,709, including 1,469 who were discharged "cured." The number of those who died was 157. Calculated according to the formula of the Registrar-General, the death-rate was 8.33. The Directors publish a mass of figures dealing with the attendance in the various departments, the distribution of the cases and the like. From table specially set out, it appears that the number of in-patients has grown more or less steadily since 1892, when it was 588, up to 1916, when it was 2,044. This number, apparently, is the sum of those who were in the Hospital at the beginning of the year and those admitted during the year. Consequently, those who were still under treatment at the end of the year are counted twice. The number of operations was 171 in 1892 and was 1,230 in 1917. It will thus be noticed that, while the number of patients have increased approximately three times, the number of operations have increased seven times. In 1892 there were 51 deaths, in 1917 there were 157. It is not permissible to calculate the death-rate on the basis of the number of patients in the hospital during the year. In 1917 there were 116 patients who were still under treatment at the end of the year. Any deaths occurring among these 116 patients would naturally be recorded in 1918. It therefore follows that these patients should be excluded from the records of 1917 altogether. The death-rate is given at 7.82 instead of 8.33, as mentioned above. In the next place, it is shown that the cost per patient treated has increased from £70 15s. 4d., in 1892, to £112 6s. 8d., in 1917. A glance at the figures shows that the cost per patient was a very different figure in 1917. What is probably meant is that £112 6s. 8d. represents 365 times the cost of maintaining one patient for one day. In the last place, it is pointed out that in 1892 740 attendances were given in the Out-patient Department, while in 1917 15,100 attendances were given. From the figures for 1917 it would appear that these 15,100 attendances were given to 3,763 patients. Boards of hospitals frequently have an insatiable desire to magnify the amount of work conducted in the out-patient departments. As the attendances given include treatment for very trivial affections or accidents, and even examinations resulting in the discovery that there is nothing whatever the matter with the patient, reasonable exception may be taken to the publication of these imposing figures.

It is stated that only one qualified resident medical officer had been obtained, and that it was necessary to appoint medical students in their fifth year to act as junior resident medical officers. This expedient is highly undesirable, but had to be adopted in the circumstances. Every endeavour had been made to secure qualified men or women for the posts.

It is pointed out that, for the present, no accommodation for children from gastro-intestinal conditions is available, and that it is necessary to place these children in the ordinary Children's Wards. The Isolation Block, too, proved quite inadequate for the accommodation of all the patients suffering from contagious affections.

A new X-ray plant was installed during the year, and will be ready for use early in the current year. A Pathological Department was fitted up and ready for occupation. Its

success in 1917, however, was similar to that of the proverbial Hamlet without the Prince of Denmark. The Directors hope to secure the services of a pathologist in 1918.

During the course of the year, Dr. W. N. Horsfall and Dr. W. R. Beeston obtained leave of absence to enable them to proceed with the military forces on active service. Dr. C. A. Clark, who was acting for one of the honorary medical officers, was compelled to retire on leaving the district.

The Medical Board comprises all the members of the honorary medical staff. It has rendered signal service to the Board of Directors.

The income of the hospital amounted to £14,700. Of this, the Government contributed a subsidy of £4,182 and special grants amounting to £5,998. The charitable public contributed £4,272. Industrial firms provided £2,442, while the patients contributed £1,644. The receipts were £884 in excess of the expenditure, and this amount was used to reduce the bank overdraft, which stood at £2,568.

Appended to the annual report is a statistical résumé of the conditions under treatment during the year classified according to the Bertillon system.

Special Correspondence.

(By Our Special Correspondent.)

LONDON LETTER.

The League of Mercy.

The Annual Meeting of the Presidents of the League of Mercy was held on December 21, 1917, at St. James's Palace. The chair was occupied by Viscount Farquhar, who presided over a large and distinguished audience.

In opening the proceedings, Lord Farquhar read the following letter from Lord Stamfordham on behalf of the King:

"I am commanded by the King and Queen to express to the meeting of Presidents their Majesties' gratification at the results of this year's work.

"A sum of £15,000 has again been handed over to King Edward's Hospital Fund for London, and more than £3,000 distributed to hospitals outside the metropolitan area. A total amount of £205,000 has been thus contributed by the efforts of the League to voluntary hospitals since its foundation. In their Majesties' opinion, this sustained activity, despite many difficulties, reflects the highest credit on all its officials and workers.

"The King has approved the institution of a Bar, to be awarded to those who shall for a long period of years have continued good services to the League, subsequently to having received the Order of Mercy.

"His Majesty has been graciously pleased to award the first Bar to Dora, Countess of Chesterfield, Lady President for South Kensington, whose district stands at the head of the list with the largest aggregate collection to its credit from 1899 to the present time."

He then stated that during the past year a marvellous amount of energy had been put into the work of the League. It was remarkable that in the fourth year of this terrible war the financial result showed a collection of £21,000, as compared with £19,920. This had enabled the League again to give £15,000 to King Edward's Hospital Fund, and £3,198 to the county hospitals.

Sir Frederick Green, speaking as Treasurer, remarked that the fact that at a time when it was estimated that £50,000,000 a year was being given in charity the League had been able to increase its subscriptions, was an eloquent tribute to the value of its work.

A subsequent address was delivered by the Speaker of the House of Commons, who said that, as one of the Statutory Governors of King Edward's Hospital Fund, he had been afraid that there must be some diminution in the grant from the League of Mercy, on account of the enormous claims that the war had made on all charitable institutions, but fortunately his fears had not been justified, because again the League had been able to hand over to the Fund no less a sum than £15,000.

The war had enabled us to realize how rich, and, at the same time, how generous, this country was. It had been the fashion lately somewhat to decry voluntary institutions,

and to suggest that the hospitals should be put on to the rates. He certainly was not in favour of such a step. So long as these institutions were well conducted, with devoted medical men willing to give their time, attention and ability to the strenuous work of the hospitals, so long as the charitable public was ready to support with their aims these absolutely essential institutions, and so long as such an organization as that of King Edward's Hospital Fund was able to ensure that the money subscribed was properly and frugally administered, it would be a great mistake to put such institutions on the rates, and to pay people to do work which others with the necessary energy and organizing powers were willing to do voluntarily. It was most remarkable that the two great life-saving organizations, the Hospitals, and the National Lifeboat Institution, should still remain the most prominent features of voluntary organization in this country.

The Ministry of Health.

A statement has been recently issued by the Royal College of Physicians of Edinburgh, dealing with the present question of the establishment of a Ministry of Health.

The College has accepted the general proposition that it would be to the advantage of the public health to have the various existing health agencies co-ordinated and brought under the supervision and control of a Board of Health, presided over by a Minister of State. For various reasons, the prevailing opinion of the College is that the establishment of this Ministry of Health ought to be delayed until after the war.

The more important points brought forward in this pronouncement may be summarized as follows:—

What is required is the creation of a Ministry which shall concern itself with health matters pure and simple, and to whose jurisdiction shall be transferred from other departments the operations of all existing enactments in so far as they deal with health. The Minister of Health must handle the whole problem. He must be concerned not only with questions already dealt with by the legislature, such as infectious diseases, infant welfare, etc., but also with fresh questions arising from time to time, e.g., conditions causing or affecting forms of sickness or disease not yet included within the operations of the Health Acts. To enable the Ministry to carry out its wide and highly complex functions, a Board of Health should be constituted, and its members selected in such a way as to ensure that the attention of the Ministry of Health would be directed to all matters affecting health. The Royal College suggests that:—

The Department should consist of the Minister and a Board of Health, of which the Minister should be chairman, and whose members should be elected on the ground of experience and interest in matters pertaining to health.

The purposes of the Department should be: (1) To administer the Health Acts. (2) To devise executive measures for dealing with health problems not hitherto defined by legislative measures. (3) To institute enquiries with a view to introducing measures for improving conditions affecting health. (4) To develop facilities for investigation of problems in health and disease as they may arise.

The Board should include three groups of members: (1) Administrative officials. (2) Laymen with wide experience of health problems, or in the administration of hospitals and other health agencies, official or voluntary. (3) Medical members who have had experience in (a) public health service; (b) general practice; (c) special clinical departments, including industrial medicine; (d) medical research; (e) medical statistics.

Correspondence.

MEDICAL MEN AND THE WAR.

Sir,—Your correspondent "South Australia" is, I think, not quite fair to the younger married men of this State. At the beginning of the war many of them, fathers, perhaps, of three or four young children, felt it rather their duty to remain at home. I think with justification. They may or may not have obtained home appointments (does your correspondent refer to civil or military appointments?), but if they did, they sacrificed something to hold them. Now that practically all the single men have gone these men feel that

their turn has come, but they find themselves at once face to face with the certainty of being away for an indefinite period of time and on a captain's pay at that. Let the military authority allow them to sign on for twelve months, as was done at the beginning of the war, and I think the younger married men will also "volunteer almost to a man."

To an impartial mind I think it will be apparent that it was and is easier for a senior man, already well established and with, probably, a creditable bank account and a solid life insurance policy, to leave his practice and his more or less grown-up family, to go abroad, than it was and is for a younger man with a very young family, who has had all the expenses of his start in life but has not had time to put himself on a sound financial basis to do the same. Moreover, the senior man went away in a senior position with a senior's pay, and last, but not least, for a definite stated period of time, I feel sure that the indefiniteness of the undertaking is keeping many men with families back at the present time.

One other point: is it possible to go abroad now? I know of several men in this State who volunteered months ago, but who are still either in their own practices or doing home service in camp or military hospital, and doing work which could be done by fifth-year students.

Yours, etc,

SOUTH AUSTRALIAN NO. 2.

VENEREAL PROPHYLAXIS.

Sir,—In your issue of September 29, 1917, Mr. G. A. Syme is reported to have made the following remarks:—

Mr. G. A. Syme thought the consideration of the matter should be deferred for some time, and in the meanwhile statistics should be collated of the effect of disseminating knowledge of this kind among our troops in Egypt. In Egypt it was arranged that Major (now Colonel) J. W. Barrett should visit all transports on arrival and carefully instruct the men in the prevention of venereal disease. That was done, and as everyone knew the zeal with which Major Barrett entered into anything he undertook, they could assume that this work was done thoroughly. When the Venereal Camp was established close to the 1st General Hospital and Major Jackson placed in charge, he collated statistics, and it was found that numbers of the men who were admitted there had used preventive measures. So far the figures have never been published, but Major Jackson had informed the speaker that the result, to his mind, was appalling. Instead of diminishing infection, it had increased the trouble. The men acted on the assurance they received that they were safe, and therefore indulged very freely, and as a matter of fact, it proved that they were not safe.

Will you, please, permit me to make the necessary corrections of fact?

(1) It is true that I was ordered to and did visit the transports as they arrived, and that I also visited the men on arrival at Cairo, and that I conveyed, to the officers a written and verbal message from the General Officer Commanding, and each of the men was handed a leaflet, a copy of which follows:

(2) By explicit direction, I did not give any instructions or make any reference to the problem of prophylaxis, beyond informing the officers that I was directly prohibited from dealing with the matter as far as they and their men were concerned.

(3) The only prophylaxis I enjoined during the period to which Mr. Syme refers, was in connexion with the A.A.M.C. unit at the 1st Australian General Hospital at Heliopolis. I gave lectures on venereal disease, on morality, and on prophylaxis, and provided prophylactic outfits for the orderlies in that Hospital, with the result that a surprise and test examination revealed the presence of only one case of infection in the unit.

(4) The prophylaxis to which Major Jackson refers, was known to me at the time. It was unauthorized, irregular, and, as far as I could tell, quite unscientific, and I can well believe it was a failure. Who suggested it to the men, I was never able to ascertain.

(5) Much as I should like to discuss the general question, it is impossible at present, but I hope I have made it clear

that Mr. Syme has been misinformed, and that the instance he narrates furnishes proof only of the partial failure of a most energetic moral campaign.

Yours, etc.,
JAMES W. BARRETT,
Lieutenant-Colonel, R.A.M.C.

Shepheard's Hotel, Cairo,
December 27, 1917.

Books Received.

- APPLIED ANATOMY AND KINESIOLOGY**, the Mechanism of Muscular Movement, by William Parry Bowen, M.S.; The Physical Education Series, edited by R. Tait McKenzie, M.D., M.P.E.; 1917. Philadelphia and New York: Lippincott. Royal 8vo., pp. 315. Illustrated with 180 engravings. Price \$3.50.
- THE PSYCHICAL FUNCTION OF THE CEREBELLUM**, by Isaac Silverman, M.B., B.S.; 1918. Melbourne: Melville & Mullen, Pty. Ltd. Demy 8vo., pp. 96. Price 5s.
- SURGICAL NURSING AND AFTER-TREATMENT**, a Handbook for Nurses and Others, by H. C. Eutherford Darling, M.D., M.S., F.R.C.S., F.R.F.P.S.; 1917. London: J. & A. Churchill. Sydney, Angus and Robertson. Crown 8vo., pp. 582. Price, 10s. 6d.

Medical Appointments.

The appointment of Dr. F. C. Turnbull (B.M.A.) as Government Medical Officer at Proserpine, Queensland, is announced in the *Queensland Government Gazette* of March 30, 1918.

Dr. J. E. F. McDonald (B.M.A.) has been appointed Assistant Medical Superintendent of the Hospital for the Insane, Toowoomba, Queensland.

It is announced in the *New South Wales Government Gazette*, of April 5, that Dr. Clifford Gearin (B.M.A.) has been appointed Government Medical Officer at Ballina, N.S.W.

Dr. James Booth-Clarkson (B.M.A.) has been appointed Deputy Commissioner of Public Health, Queensland, during the absence of the Commissioner of Public Health.

Dr. Stewart Macky (B.M.A.) has been appointed Coroner at Lockhart, New South Wales, and a Coroner for the State generally.

Medical Appointments Vacant, etc.

For announcements of medical appointments vacant, assistants, locum tenentes, etc., sought, etc., see "Advertiser," page xv.

Department of Public Health, N.S.W., Second Government Medical Officer.

Medical Appointments.

IMPORTANT NOTICE.

Medical practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429 Strand, London, W.C.

Branch.	APPOINTMENTS.
VICTORIA. (Hon. Sec., Medi- cal Society Hall, East Melbourne.)	All Friendly Society Lodges, Institutes, Medical Dispensaries and other contract practice. Australian Prudential Association Proprietary, Limited. National Provident Association. Life Insurance Company of Australia, Limited. Mutual National Provident Club.
QUEENSLAND. (Hon. Sec., B.M.A. Building, Ade- laide Street, Bris- bane.)	Medical Officers to the Selwyn Hos- pital, North Queensland. Brisbane United Friendly Society In- stitute. Cloncurry Hospital.

Branch.	APPOINTMENTS.
SOUTH AUSTRALIA. (Hon. Sec., 3 North Terrace, Adelaide.)	The F.S. Medical Assoc., Incorp. Adelaide. Contract Practice, Appointments at Renmark.
WESTERN AUSTRALIA. (Hon. Sec., Health Department, Perth.)	All Contract Practice Appointments in Western Australia.
NEW SOUTH WALES. (Hon. Sec., 30-34 Elizabeth Street, Sydney.)	Australian Natives' Association. Balmain United F.S. Dispensary. Canterbury United F.S. Dispensary. Leichhardt and Petersham Dispensary. M.U. Oddfellows' Med. Inst., Elizabeth Street, Sydney. Marrickville United F.S. Dispensary. N.S.W. Ambulance and Transport Bri- gade. North Sydney United F.S. People's Prudential Benefit Society. Phoenix Mutual Provident Society. F.S. Lodges at Casino. F.S. Lodges at Lithgow. F.S. Lodges at Parramatta, Auburn and Lidcombe. Newcastle Collieries — Killingworth, Seaham Nos. 1 and 2, West Wall- send.
TASMANIA. (Hon. Sec., Bel- grave, Tasmania.)	Medical Officers in all State-aided Hospitals in Tasmania.
NEW ZEALAND: WELLINGTON DIVISION. (Hon. Sec., Wel- lington.)	Friendly Society Lodges, Wellington, N.Z.

Diary for the Month.

- Apr. 16.—N.S.W. Branch, B.M.A., Executive and Finance Committee.
 Apr. 17.—W. Aus. Branch, B.M.A.
 Apr. 18.—City Med. Assoc. (N.S.W.).
 Apr. 19.—Q. Branch, B.M.A., Council.
 Apr. 19.—Eastern Suburbs Med. Assoc. (N.S.W.).
 Apr. 20.—Northern Suburbs Med. Assoc. (N.S.W.).
 Apr. 23.—N.S.W. Branch, B.M.A., Medical Politics Commit-
tee; Organization and Science Committee.
 Apr. 24.—Vic. Branch, B.M.A., Council.
 Apr. 24.—Western Suburbs Med. Assoc. (N.S.W.).
 Apr. 26.—N.S.W. Branch, B.M.A.
 May 1.—Vic. Branch, B.M.A.
 May 3.—Q. Branch, B.M.A.
 May 10.—N.S.W. Branch, B.M.A., Clinical.
 May 14.—Tas. Branch, B.M.A., Council and Branch.
 May 14.—N.S.W. Branch, B.M.A., Ethics Committee.
 May 15.—W. Aus. Branch, B.M.A.
 May 16.—Vic. Branch B.M.A. Council Election of Repre-
sentatives on Representative Body.

EDITORIAL NOTICES.

Manuscripts forwarded to the office of this Journal cannot under any circumstances be returned.

Original articles forwarded for publication are understood to be offered to *The Medical Journal of Australia* alone, unless the contrary be stated.

All communications should be addressed to "The Editor," *The Medical Journal of Australia*, B.M.A. Building, 30-34 Elizabeth Street, Sydney, New South Wales.